AN INTERPRETIVE DESCRIPTION OF THE PATTERNS OF PRACTICE OF ARTS THERAPISTS WORKING WITH OLDER PEOPLE WHO HAVE DEMENTIA IN THE UK

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Abstract

In recent years there has been growing interest in arts therapy work with older people who have dementia. This has happened despite a paucity of UK research and writing on the aims of practice. Furthermore, there is little knowledge about the professional background of practitioners, the client group, care settings, theories and methods underpinning their work.

This qualitative mapping study employs a methodology from nursing called interpretive description (Thorne et al. 2004). Interpretive description advocates a pluralistic approach for understanding the complex dialogue between clinical and research knowledge. The research design involved thirty-one semi-structured interviews with arts therapists from art therapy, music therapy, dramatherapy and dance movement therapy, participant observations of thirteen care settings and formal and informal interviews with ten medical/care staff who work with the arts therapists. The descriptive map was analysed using template analysis (King, 1998) and was interpreted using an integrative interpretive analysis (Heidegger, 1927; Smith et al.1999)

The findings suggest that many arts therapists are pioneers in terms of being the first from their profession to work in the care setting. Issues around the arts therapists *being unheard* and *staying unheard* relate to their newness within these established settings. In terms of therapy work, theory and practice were being adapted in order to accommodate the temporal nature of the work. Despite distinctions in the art form, the study found that there is reciprocity of experience in terms of the arts therapists' feelings about the work and some in-session practices. These united the disciplines beyond the norms of mainstream practice.

Key words: Dementia, Arts Therapies, Art Therapy, Music Therapy, Dramatherapy and Dance Movement Therapy.

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I would like to dedicate this thesis to my parents

William and Margaret Burns

Your unfailing love and support have guided me throughout life.

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List of Abbreviations and Working Definitions

AT – Art Therapy

MT – Music Therapy

DT – Dramatherapy

DMT – Dance Movement Therapy

AD – Alzheimer's Disease

Arts Therapists: UK trained therapists from the fields of art therapy, music therapy, dramatherapy and dance movement therapy.

Care Setting: NHS, voluntary or private day or residential care setting.

Dementia: "Disease of the brain usually of a chronic or progressive nature…"
(World Health Organisation, 1992)

Descriptive Map: a written description pertaining to the professional background of the arts therapists, where and with whom they work, how they work in terms of their therapy work and their reflections on their practice.

Mapping: is defined as the *searching for* and *gathering of* accounts of arts therapy practice.

Patterns of Practice: an umbrella term to define the patterns of connection between all the elements in the study.

Practitioner-Researcher: clinician who undertakes research.

Professional Background of Arts Therapists: an umbrella term used to define the prior training and career of the arts therapists and their journey into the dementia field.

Older Person: a person over sixty-five years of age.

Therapy Space: refers to the room where the arts therapy session takes place.

Therapy Work: an umbrella term pertaining to the referral, assessment and evaluation procedures, theoreticians/ theories and in-session methods arts therapists employ.

Chapter One - Introduction

> "I am but a draper in a room of wool, looking at the patterns, feeling like a fool. I'm going to take my fabric, stretch it to the seams. I want to find what's woven underneath these tailored dreams" (Bowles, 2004, p.1).

Arts as therapy

The arts as a source of healing have been understood since ancient times (Lynch, 1987). The popularity of the arts in Western culture has waxed and waned with the passing doctrines of the ages (Karkou and Sanderson, 2006). The arts therapies as they are currently understood emerged during the late nineteenth and early twentieth century (Jones, 2005). Their rise is accredited in part to the revolution in the arts during that period and in part to the rise of modern psychotherapy led by the psychoanalysts Sigmund Freud and Carl Jung (Karkou and Sanderson, 2006). The revolution in the arts took the shape, in art, of a move away from formal art towards a more naive, experiential style of art. Art was used for the first time by psychiatric patients, such as Aldolf Woelfli in the Waldau Clinic Berne, as a type of catharsis. In France, Jean Debuffet and in Vienna, Franz Cizek, a member of the Vienna Secession Movement, were interested in *art brut,* a form of outsider art (McGregor, 1989; Waller, 1992). In music, Schönberg developed his twelve-tone technique (Bachlund, 2008). In drama, Iljine, Evreinov and Moreno were developing their understanding of theatre as therapy, educational drama and psychodrama (Jones, 2007). In dance, the pioneering work of the Austrian dance theorist Rudolf Laban emerged at the same time as dancers like Isadora Duncan and Mary Wigman transformed dance on the stage into a modern form of art; one that was more accessible to wider audiences and closely connected to emotional expression (Levy, 1995; Karkou and Sanderson, 2006).

In the UK, the arts and psychotherapy came together most prominently during the Second World War when shell-shocked soldiers returned from the fighting to be treated by psychoanalysts in large psychiatric hospitals. Often unable to speak of

their terrible experiences, alternatives to verbal communication were sought; among these were art, music, drama and movement.

Since the 1940s art therapy (AT), music therapy (MT), dramatherapy (DT) and dance movement therapy (DMT) have emerged, despite their shared core philosophical underpinnings, to have their own distinct postgraduate training courses and professional associations (Jones, 2005; Karkou and Sanderson, 2006). AT, MT and DT became state registered in 1997 by the Health Professions Council (HPC). Registration for DMT is currently under completion. All arts therapies training programmes are at postgraduate level. Full-time courses last between one and two years and provide trained arts therapists with a generic training. Specialism in a field, such as dementia, happens post training when the arts therapist begins to develop his/her interest in working with a specific client group.

Dementia

Today the World Health Organisation (WHO) defines dementia as follows:

> "Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is a disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, language and judgement" (WHO, 1992, p.1).

Dementia is an umbrella term for a biomedical concept that describes "symptoms that occur when the brain is affected by specific diseases and conditions" (Alzheimer Society, 2007, p.1). Alzheimer's Disease (AD) is the most common form of the degenerative disease, accounting for about sixty-two percent of those diagnosed (Alzheimer Scotland, 2008). There are many other types of dementia, all with their own distinct variables. It is estimated that worldwide around twenty-four million people currently have dementia and by 2040 that number will rise to eight-one million (10/66 Dementia Research Group, 2008). The reason for this increase is attributed to the fact that people are living longer due to improved economic and social factors.

Dementia is a complex condition that in biomedical terms is characterised by atrophy and early hippocampus shrinkage (McKeith et al. 2001). Senile plaques or lesions and neurofibrillary tangles, molecules constructed of protein, are present in the brain of a person with AD to a much larger extent than in a normal brain (Sutcliffe, 2001). According to the Alzheimer Society (2007), no single factor has been identified as the cause of AD; it is likely that a "combination of factors, including age, genetic inheritance, environmental factors, diet and overall general health are responsible" (Alzheimer Society, 2007, p.1). Diagnosis is made on the "basis of exclusion of some possible factors and the presence of others" (Burns et al. 2001, pp.7-8). The general practitioner (GP), the person's first point of contact, will undertake an initial clinical interview with the person using the Mini-Mental State Examination (Folstein et al. 1975). Having ruled out any potential physical symptoms, the GP will refer the person to a specialist gerontologist to determine if dementia is present.

In biomedical terms the person is considered to move through a series of three progressive (early, middle and late) stages of the disease (Sutcliffe, 2001). Early stage dementia is characterised by small changes in the person's ability to remember and concentrate on day-to-day activities. In the middle stage of dementia the person may experience more apparent memory loss and he/she may increasingly become disorientated to time and place and may even experience hallucinations. In the later stages of dementia the person may completely withdraw from the world as his/her cognitive and physical ability to function deteriorates (Whalley, 2001; Burns et al. 2001).

Arts therapies with older people who have dementia

The rationale underpinning the biomedical model stems from the Enlightenment Movement of the Eighteenth Century, a period when the "reason and rationality" of science and technology were viewed as the way forward for human development (Bond, 2001, p.45). The physical body was understood in mechanical terms as a mechanism to be repaired; little account was given of the person's psychological and emotional well-being. The predominance of such thinking led, in part, to the late development of therapeutic interventions for people who have dementia. For

example, arts therapists have only worked with this client group for the last twenty-years (Aldridge, 2000). Historically, arts-type activities were available to a select few psychiatric patients, including those with senile dementia, in the asylums of the 1860s and onwards until the close of the large psychiatric hospitals in the 1980s (Skailes, 1997; Waller, 2002). However, the majority of people who had dementia had no access to an arts therapy service or in fact any type of psychotherapeutic intervention (Cheston and Bender, 1999).

Psychotherapists, like other health care professionals, were pessimistic about the potential benefits of psychoanalysis for older people, particularly for those with progressive illnesses such as dementia. Freud (1904, p.48), for example, commented that; "near or above the fifties the elasticity of the mental processes, on which the treatment depends, is as a rule lacking…" Psychoanalysts perceived that the person did not have the capacity for in-depth insight into his/her own behavioural drives and motivations and therefore lacked the ability to make conscious self-perceptions. The person was viewed as having insufficient defences to cope with the "internal and external assault on the ego" (Symer and Qualls, 1999, p.61) that participation in psychoanalysis required. Cheston and Bender (1999) felt that there was a much simpler explanation; psychoanalysts were not interested in working with anyone old. The writers believed that; "psychoanalysts framed rules of exclusion to remove the less attractive of those needing help with little or no respect for the evidence relating to those exclusions" (1999, p.101). Butler (1963) viewed this differently; he felt that the older person was an appropriate candidate for psychotherapy because he/she was at an age where he/she had a strong desire to reflect on his/her life. Butler's (1963) early writing focused on reminiscence work with the general elderly population but since the 1980s it has been widely used with older people who have dementia.

Despite this early development it was not until the late 1980s that there was a full awakening within the dementia profession to the psychological needs of the person. During this period Tom Kitwood, (1937-1998) and colleagues (Kitwood, 1988, 1989, 1990, 1993, 1997; Kitwood and Bredin, 1992; Kitwood and Benson, 1995) began to develop a *new culture of dementia care,* one in which the *person* not the disease was important. Kitwood (1997) realised that the biomedical model's emphasis on brain functioning and cognitive loss was restrictive because it standardised the type

of care that the person received. In focusing on the body's deficits no account was taken of the psychological needs of the person; the multiple losses, fears and complex relationships that the person experienced as a result of having dementia. Kitwood and colleagues (Kitwood, 1988, 1989, 1990, 1993, 1997; Kitwood and Bredin, 1992; Kitwood and Benson, 1995) envisioned a psychosocial approach to the care of people with dementia, an approach that was underpinned by person-centred principles.

The shift in focus away from the disease to the person led professionals working in the dementia field to consider engaging with the person in different ways, for example through non-verbal communication and arts activities (Goldsmith, 1996; Killick and Allan, 2001; Alan, 2002; Hubbard et al. 2002). Such developments augmented interest in employing largely non-verbal modalities such as the arts therapies. In year 2000, David Aldridge, the Germany-based academic, edited the first collection of UK published international writing on MT and dementia practice. Two years later, Diane Waller, writing in the seminal book *Arts Therapies and Progressive Illness: Nameless Dread,* gave the first UK definition of the arts therapies with this client group:

> "The arts therapies are 'person-centred' and importantly, build on the positive attributes of patients, assuming that all can be creative at some level. The material and methods of the arts therapists are flexible, and a skilled therapist assesses the patient's capabilities, gently encouraging and supporting even the smallest sound, mark or movement "(Waller, 2002, p.2).

The definition offers for the first time, an understanding of the type of work that the arts therapist undertakes with his/her client(s). A person-focused, supportive relationship is envisaged, one that engages the person's creativity whatever his/her capability.

Parameters of the study

> "There comes a time in the development of ones professional work, when it seems necessary to move outside the doing of the work and look more closely at the nature of what one is doing, to question, to sharpen understanding, to submit belief and conviction to rigorous scrutiny" (Hill, 2006, p.166).

Heather Hill's (2006) words resonated with my own experience. There came a point in my own clinical work as an art therapist working with people who have dementia when I wanted to develop my own knowledge of AT practice with this client group. For several years I worked as the only art therapist on a series of small short-term projects in central Scotland. I found there were a lot of misconceptions about the work and about my role; ranging from me being an activity officer to someone who could diagnose clients' states of dementia by the images they produced. These misconceptions arose because the care staff and managers in the day and residential settings where I worked had never worked with an art therapist before. This meant that in each new setting I had to spend a considerable amount of time explaining what AT was, how I worked and what I needed in terms of resources and space. While the members of staff were usually very accommodating I sometimes felt as though I was stuck in a vortex of self/profession-promotion, when in fact what I wanted to do was to get on with the work. Hill's (2006, p.166) comment that she found it necessary to "move outside of doing the work (in order to) look more closely at the work" is the point that I reached when I decided to return to university and write my MSc dissertation on the topic of AT with clients who have dementia. My MSc supervisor was a dance movement therapist who had researched widely in the general arts therapies field. This introduction to another arts therapist sparked my interest in the other (DMT, MT and DT) arts therapies and how arts therapists from these professions worked with older people who have dementia.

I undertook a brief literature search where I discovered that there was no comprehensive picture of how arts therapists worked with older people who have dementia in the UK; instead what existed was a very small collection of case study descriptions by individual arts therapists discussing their own particular way of working. Valuable as these case studies were, they offered no detailed explanation of the arts therapists model of practice in terms of his/her referral, assessment and evaluation procedures, theories/theoreticians and critique of the methods he/she used in-session.

In terms of empirical research studies I found that one large longitudinal study had been undertaken by Sheppard et al. (1998) on art therapy and depression and two small quasi-control trial studies one in MT by Odell-Miller (1995) and one in DT by Wilkinson et al. (1998).

In light of the paucity of UK writing and research I felt there was an urgent need to generate a first account or *map* of the field.

Study aims, research questions and objectives

The first aim of the study was to map the arts therapies and dementia field, to create a descriptive account of the similar and different patterns of practice of arts therapists working in the field. The second aim was to interpret the descriptive map and explore its meanings. The third aim was to create a list of practice statements that would be useful for practitioners working in the field.

The research questions were as follows:

- Who are the arts therapists, where and with whom are they working?
- How do arts therapists work in terms of their therapy work?
- How do the arts therapists experience the work?
- What are the emerging patterns of practice?

These were translated into tangible objectives as follows:

- To locate UK therapists from the four primary arts therapies fields of AT, MT, DT and DMT.
- To conduct individual semi-structured interviews with the arts therapists.
- To visit, where possible, the practice setting in order to see where the arts therapist worked, to have a look at the therapy space and to meet and informally interview any medical/care staff that the arts therapist worked with
- Ultimately to create a descriptive map of the field, to offer some interpretations of the map and following that to generate a set of practice statements that would be useful for practitioners working in the field.

Research philosophy, methodology and methods

In order to generate a first descriptive account of arts therapy and dementia practice the field required mapping.

Mapping the map

In geographical terms a map offers a visual representation of a particular location; it depicts the different landscapes, regions and objects pertaining to that area. In terms of this study, the concept of mapping will be used to bring together for the first time a textual description of the key areas (professional background of the arts therapists, where and with whom they work, how they work in terms of their therapy work and their reflections on the work) that underpin arts therapies practice with older people who have dementia. The aim is to provide a map of the field so that arts therapists and non-arts therapists have an understanding of what constitutes arts therapy practice with this client group.

The starting point for mapping the field will be the *searching for* and *gathering of* accounts of arts therapies practice from practitioners working in the field. The themes emerging from these accounts will be analysed using template analysis (King, 1998) and synthesised into a descriptive map of the field. The notion of mapping fits with the principles of *interpretive description* (Thorne et al. 2004) a methodology that emerged from the field of nursing. Studies employing interpretive description offer a thematic description of a clinical phenomenon (Thorne, 2008, p.75).

Interpreting the map

Creating a descriptive account of the phenomenon is one element of the interpretive description study the other engages the practitioner-researcher in interpreting what has been mapped. Thorne (2008, p.50) suggests that; “the clinical mind tends not to be satisfied with the ‘pure’ description but rather seeks to discover associations, relationships and patterns within the phenomenon that has been described.” The practitioner–researcher’s *a priori* knowledge of the clinical

field will most likely have been the impetus for undertaking the research project and as such he/she will want to reflect on the patterns that emerge from the descriptions. In this study I employed an integrative interpretive analysis in order to explore the meanings behind the descriptive map.

Terminology and the use of the first person

The issue of terminology is a prevalent topic within the dementia profession. The shifting of the dementia care model from the biomedical to the psychosocial has encouraged more semantic alliance with regard to how the person who has dementia is defined. An issue that arises in this thesis is the bringing together of the two different cultures; the arts therapies on the one hand and the dementia care profession on the other, each of which has its own linguistic conventions. In order to accommodate this cultural diversity this study adopts a pluralistic approach to terminology. Psychosocial writers in the dementia care field use the singular term *person* to refer to the older person who has dementia. In doing this they omit any reference to the person's age (older) or state of health (who has dementia). In this study the same convention is adopted here, although reference is made to, *older people who have dementia* in order to contextualise the study. Older terms such as *elderly* and *geriatrics* are used only in the literature review when referring to literature from a particular period in time.

Arts therapists use the term *client* or *clients* when referring to the person(s) that they work with. Hospital-based arts therapists sometimes refer to the person they work with as *patient* or *patients*. In this study the term *client* or *clients* is primarily used. In terms of referring to the actual arts therapists and their specific discipline, again a pluralistic approach is adopted. Each discipline is referenced by the abbreviations AT, MT, DT and DMT but when speaking about the actual arts therapists the full name is written (e.g. music therapists). The reason for the use of abbreviations is that wordage becomes an issue particularly in the descriptive map chapters when each arts therapist is identified by his/her discipline.

In line with current conventions in qualitative research I adopt the use of the first person. Holloway (1997) observes that the use of the first person in qualitative research can be justified because the researcher acts as the primary research tool.

The qualitative researcher engages with the participants and takes a subjective rather than objective role in the study.

Study overview

Chapter one has given an overview of the study. Chapters two to five are the literature review. The first of these chapters charts the developments in dementia care before exploring the policy and the research initiatives that have happened in the last twenty years. The chapter concludes by considering the issues prevalent in today's dementia care setting. Chapter three looks at the psychosocial and psychological influences that have helped bring the arts therapists into the dementia care setting. The chapter begins by describing the psychosocial paradigm shift that took place in the dementia care setting. It moves on to outline the therapeutic activities that took place in some day and residential care settings in the 1980s. The emergence of activities within the care setting, combined with the development in psychosocial care, awakened psychotherapists to the potential of psychotherapy with the older person. As primarily non-verbal forms of psychotherapy, the arts therapies emerged as potentially important forms of therapeutic support for the person experiencing communication difficulties. The chapter concludes by discussing the role of arts in the care setting and the current debate with regards to art as an activity versus the arts as a therapeutic intervention. Chapter four offers a chronological map of the pre-1990 and post-1990 national and international older people/dementia arts therapies literature. The chapter concludes with a thematic summary of the overarching themes emerging from the chapter. Chapter five narrows the focus of the study to look at key areas of practice within the UK/European literature. The areas under consideration are the professional background of the arts therapists, the older person with dementia, the type of care setting the arts therapists work in and their in-session therapy work. Chapter six discusses the research methodology and outlines the methods and procedures adopted during this study. Key to this is a discussion of the terms *mapping* and i*nterpreting* and how these two concepts come together in the methodology *Interpretive Description* (Thorne et al. 2004). The chapter concludes by considering issues of trustworthiness and the ethical procedures related to this study. Chapters seven to ten present the descriptive map; here a full account of the analysed interview transcripts is presented. The map describes the professional

background of the arts therapists, the client and care setting, therapy work and the arts therapists' reflections on their practice. In chapter eleven, the interpretive chapter, a selection of key themes from the map are interpreted and discussed within the context of the literature reviewed. Chapter twelve, the conclusion, summarises the key patterns of practice that have emerged from this study and generates these into practice statements. Strengths and limitations of the research as well as recommendations for clinical practice and future research are also considered.

Chapter Two

Developments in Dementia Care

Overview

Chapters two and three offer a review of the background literature pertaining to the topic of this study. In this chapter the type of health care service currently available to the person who has dementia is discussed. Consideration is given to the historical changes that have taken place in terms of care provision and in particular relation to the move of this client group from large psychiatric hospitals to small community residential homes via day care units. The move towards different types of care provision prompted questions about the quality of care the person received. Changes in dementia care paralleled the move in health care research towards evidence-based practice (EBP). Arts therapists have become engaged in this debate (Gilroy, 2006). The chapter concludes by returning to the care setting and considering what issues remain as a result of the changes that have taken place.

Chapter two begins by outlining the literature review search strategy employed in this study.

Literature review strategy

My literature review was guided by certain inclusion and exclusion criteria; these are outlined in table one.

Table 1 – Literature Inclusion and Exclusion Criteria		
Category	Inclusion Criteria	Exclusion Criteria
"Older Person"	Pre-1990 • Geriatric • Elderly • Elders (US term) • Older people Post-1990 • Elderly • Elders • Older people • Older person	Functional
"Dementia"	*Degenerative • Alzheimer Disease • Lewy Bodies *Frontal Lobe • Frontal Lobe Dementia • Picks Disease *Vascular • Vascular dementia	*Toxic • Alcohol related *Transmissible • CJD • Aids related dementia *Metabolic • Hypothyroidism
"Arts Therapies"	• Arts/arts activities in the care setting • Arts therapies • Specialised arts therapies literature	• Crafts • Arts activities other than Art, music, drama and dance

*Source: McKeith and Fairbairn (2001)

My aim was to keep the inclusion criteria as wide as possible because a first search of the arts therapies and dementia literature revealed that UK writing in the field was limited. One reason for this was that the field is relatively new in comparison to other arts therapy areas of practice such as work with children (Smith, 2004). Recognising that the field required contextualising I felt that an initial general scoping of the literature would allow me to chart the changing patterns in the social, political and psychological thinking that facilitated the emergence of specific arts therapies and older people/dementia writing. I then decided to employ a general to specific strategy which used the year 1990 as a marker to signal the move between general (pre-1990) and specific (post-1990) literature in the arts therapies and older people/dementia chapter. The reason for this year choice was that 1990 heralded the beginning of the psychosocial revolution in dementia care, which in turn awakened interest in the potential of the arts therapies with this client group.

Despite the breadth of my initial search I did impose some exclusion criteria within the three primary categories of ‘older person’, ‘dementia’ and ‘arts therapies’. In terms of the ‘older person’ category I initially attempted to exclude arts/arts therapies literature with older people with a functional illness (e.g. depression or stroke) but when I searched the literature I found that early writers included case examples of work with older people experiencing functional and organic illness. I therefore frequently had to use my clinical judgment and the knowledge gained during the research to unpick some of articles so that I had a clear understanding of when the writer was speaking of working with a person with a functional as opposed to an organic illness. There were also many overlapping psychological issues and conditions between the two groups, for example a person diagnosed with a functional disorder moving into residential care may experience similar feelings of confusion, depression and anxiety as a person diagnosed with dementia moving into residential care (Waller, 2002).

In terms of the ‘dementia’ category I excluded literature related to toxic, transmissible and metabolic dementias (McKeith and Fairbairn, 2001) because of their different aetiologies and also impact on a younger client group. I recognise that by employing such criteria (‘dementia’, ‘Alzheimer’s disease’, ‘toxic’ etc…). I am not rejecting the use of biomedical terminology as some contemporary dementia writers have done (Bender, 2003). However, I concluded that while not necessarily preferable (in terms of historical connotation) such terminology does provide a recognisable reference point for the reader and these terms are currently employed, to varying degrees, by both biomedical and psychosocial writers in the field.

The exclusion criteria I had for the arts/arts therapies literature was art, music, dance or drama writing that was not specifically located within the older people/dementia care setting. I excluded writing in all other forms of art such as poetry/poetry therapy and writing on arts and craft activities.

During my search of the Queen Margaret University library databases I used primarily PsychINFO, pre-CINAHAL and CINAHAL-plus, Medline and Cochrane

Table 2 – Examples of Arts Therapies Database Search Strategy		
Category	Databases	Search Strategy Criteria
"Arts Therapies"	EBCSO Host: PsychINFO pre-CINAHAL CINAHAL-plus Medline Cochrane	Pre-1990 • Geriatric/elderly/elders/older people + arts/arts activities + care setting • Geriatric/elderly/elders/older people + arts therapies • Geriatric//elderly/elders/older people + specific arts therapy Post-1990 • Dementia + arts/arts activities • Dementia + arts therapies • Dementia + specific arts therapy • Specific dementia + arts/arts activities • Specific dementia + arts therapies • Specific dementia + specialised arts therapies

Library. Table two indicates the general-to-specific search strategy that I adopted when looking for the arts/art therapies and older people/dementia literature.

The parameters of the search included background literature related to dementia care, policy and research initiatives and psychosocial and psychotherapeutic writing pertaining to older people/older people who have dementia. In terms of the arts therapy literature, national and international peer-reviewed writing (1970 -2007) was consulted, primarily in the form of journal articles and book chapters offering case study descriptions of in-session practice, practice guidelines and discussion of recent empirical research findings. The inclusion of international literature in the review is in line with the current trend in the arts therapies and dementia literature. The paucity of UK-specific literature has meant that writers frequently use international sources to reference particular ideas. "Grey literature" (unpublished research) is occasionally referenced in the absence of peer-reviewed national and

international literature. The reality is that the arts therapies and dementia field is in its infancy and like any young child many strands influence its development.

Society's view of the older person

Western society's preoccupation with youth and beauty over age and experience undermines the older person. The older person in physical and/or mental decline is often rejected and perceived as a 'persona non grata' (Tyler, 2002, p.69). Tyler (2002) reflects on the reasons for this:

> "Older adults are frequently viewed by society as less attractive and there may be many reasons why care staff avoid getting 'too close' to them. In a culture that praises youth and vigour, communicating with older people can bring us in touch with our own ageing process, and perhaps that of our parents. We can begin to examine our wrinkles and blemishes. In other words, we can get in touch with our mortality and our beliefs about what happens when we die" (Tyler, 2002, p.69).

The consequence of viewing the older person in such negative terms pervades all areas of our society. For example, in terms of care provision, Smith (2004) notes that a 'Cinderella' service characterises much of older peoples psychiatric care in the UK.

Care settings

Historically, the older person with dementia was cared for in a large psychiatric hospital, many of which had been former workhouses. Major changes took place in care provision for psychiatric patients following the 1990 Community Care Act and with the introduction of neuroleptic drugs (Wood, 1997; Pilgrim and Rodgers, 1999).

The tenet of the Community Care Act 1990 was that the person should remain in his/her own home for as long as possible. Day centre or day hospital care was set up to offer the person's primary carer respite from the daily and nightly care of their loved one (Sutcliffe, 2001). Traditionally, having been fully assessed by the multi-disciplinary team the person would attend day care a few times a week during which time he/she might participate in activities such as gardening, listening to music, arts and crafts. Increasingly, more formal therapeutic support such as the

arts therapies are being offered to the person receiving day care (Burns, 2003). However, as the person's dementia progresses and relatives find it increasingly difficult to care for their loved one at home, the prospect of a move from day into community NHS, voluntary or private residential care becomes a reality.

When a place in community residential care is not available, the hospital can act as a short or long-stay setting for the person. Typically, a psychogeriatric unit within a hospital would have two wards, one a continuing care ward for long-stay patients and the other a short-stay assessment ward. Alongside these wards would be a day hospital where the person would begin treatment as an outpatient and then, as the disease progressed, be assessed for residential care. In this event usually the person would be allowed to attend the same Occupational Therapy (OT) or arts therapy groups already started in outpatients. OT departments are common within psychogeriatric wards. Arts therapists first found their way into the hospital setting traditionally via the OT department (Towse, 1995).

Policy and research developments

During the 1990s the move towards psychosocial care prompted campaign groups to question how health authorities allocated their financial resources to the care of older people who had dementia. Fundamental discrepancies became evident in the way that health authorities in England managed these resources. The Alzheimer's Disease Society (1997) survey of local health authorities in England uncovered that, shockingly; "79% of health authorities were unable to identify the resources they spent on dementia services" (Cantley, 2001, p.207). Reports such as this prompted health authorities to take action and plan for better service delivery; however as late as the Audit Commission (2000) it was found that the majority of these plans were still "underdeveloped" (Cantley, 2001, p.207). In light of such failings national policy focused on "improving standards and making them explicit" (Cantley, 2001, p.210).

Older people came finally on the political radar in 2001 with the publication of the National Service Framework (NSF) for Older People (2001) which proposed the first set of national standards for the care of older people in the UK (Nolan et al., 2001). The report sets out eight standards of integrated health and social care for older

people in England; standard number seven relates to mental health problems in this population. It states that;

> "Older people who have mental health problems (should) have access to integrated mental health services, provided by NHS and councils to ensure effective diagnosis, treatment and support for them and their carers" (Department of Health, 2001b, p.90)

The report envisions an integrated health service framed around the community multi-disciplinary mental health team. The two central aims of NSF were the delivery of "person-centred" care and the ending of ageism and practice which discriminates the older person (Nolan et al. 2004). However, while the report recognised that this was the preferred model (already used in adult mental health) it acknowledged that there were limited published accounts of this type of work in older peoples services. In Scotland a similar report was produced by the Chief Medical Officer; the "Adding Life to Years" (Scottish Executive, 2002) advocated that NHS boards work to bring awareness of older peoples mental health issues to the fore and that multi-disciplinary teams plan and deliver appropriate services. Such government publications have opened the door to policy initiatives promoting autonomy and empowerment for the older person (Cantley, 2001). Within this context there has also been a raft of research published by non-governmental organisations such as Economic Social Research Council and the Joseph Rowntree Foundation looking at topics such as the *consent process* (Wilkinson, 2002), *inclusion* (Hubbard et al. 2003), *quality of life* (Tester et al. 2004). For example, in terms of quality of life measures Hendry and McVittie (2004) question how an older person's life can be measured when life is such a subjective experience.

In terms of policies relating to assessing clinical practice, institutes like NICE (National Institute for Clinical Effectiveness) and SIGN (Scottish Intercollegiate Guidelines Network) focus on evidence-based practice (EBP) with research being viewed within the hierarchy of evidence established by the NHS Centre for Evidence-Based Medicine (in which there is a grading of "best" evidence from RCT (Randomised Control Trial) at level one to a consensus of expert opinion at level five. SIGN's national clinical guideline on the *management of patients with dementia* is based around this hierarchy. It considers MT in the following way:

> "Evidence from a series of underpowered studies suggests that exposure to music, tailored to meet the individual's need, can relieve agitation but not aggressive behaviour in people with dementia. It is not possible to determine whether the beneficial effect seen is the result of music therapy itself or other factors, such as the presence of the researcher. Music therapy is easy to implement, but more research is needed to determine whether it is beneficial to the person with dementia" (SIGN, 2006, p.23).

Issues arise for arts therapists and other psychological therapists in terms of this grading system as such therapies do not generally fit easily into these research traditions because of the relational nature of the work. It is hard to quantify the changing dynamics of the therapeutic relationship, this is illustrated in phrases from the above SIGN statement such as; "it is not possible to determine the beneficial effects…" and "music therapy is easy to implement" (SIGN, 2006, p.23) These phrases demonstrate a lack of understanding of firstly the potential quality and significance of the MT encounter and secondly of the complexity of establishing and maintaining a therapeutic relationship.

Whatever critique you choose to place on the SIGN statement, it is not easy to ignore the main tenet of the writing that there has been a lack of MT research. The same message could easily be applied to the other arts therapies, particularly in light of the fact that they do not have SIGN statements. This begs the question, how do arts therapists evidence arts therapy practice? Gilroy (2006) argues that such expert opinion should be given more recognition. She suggests that there is a need for art(s) therapists to develop their own level of evidence, one that reflects the predominance, in the art(s) therapy literature, of case study descriptions of in-session practice. One of the most influential policy initiatives in terms of this study has been the development of the NHS Quality Improvement Scotland Best Practice Statements (BPSs) (Quality Improvement Scotland, 2005). The statements are developed, following a piece of research in the field, by the practitioner-researcher in order to better understand the clinical field. Information on practice is gathered from the "best available evidence" (Quality Improvement Scotland, 2005, p.2) for dissemination among other practitioners and those working with them.

In light of such developments this chapter concludes by returning to the dementia care setting and considering the issues that are prevalent today.

Issues in today's care setting

In the last eighteen years there has been a fundamental shift in dementia care. Mary Marshall (2001) reports that person-centred care is the aim in today's dementia care setting. However, she acknowledges (Marshall, 2001, p.173) that this type of care "is not easy to achieve and many settings fall short." The reason is that the expectations on underpaid and untrained staff are unrealistic. Today many older people still sit in the lounge unoccupied; "shutting themselves off from their surroundings, sitting with bent head and fixed gaze, absorbed totally in almost automatic hand movements" (Lev-Aladgem, 2000, p.4). Often the system becomes so bureaucratic that the purpose of their work, to care for the older person with dementia, gets lost.

Waller (2002) observes that there is still a need for the person to be engaged in some form of meaningful activity (e.g. providing sensory stimulation) in order to help combat his/her premature physical and mental decline. Waller (2002) suggests that the care setting must help the person to maintain existing skills and where possible improve his/her quality of life. However, with the rise of mixed often under-funded community care the "problem of unmet psychological and social needs of elderly people (…) shifted to a variety of agencies, few of which provided professional therapeutic support" (Towse, 1995, p.324). Twelve years on from Towse's (1995) pessimistic observation there are some signs that the situation is slowly beginning to change.

Chapter summary

- Society's view of the older person is still rooted in ageism. Youth and beauty are favoured over age and experience. Mirroring this societal trend, older peoples psychiatric services in the UK have been characterised as "Cinderella" services (Smith, 2004).

- The 1990 community care act shifted the provision of care from the large psychiatric hospitals to the community day and residential care setting. Day centre or day hospital care offers the person's primary carer respite from the

daily and nightly care of their loved one (Sutcliffe, 2001). Increasingly, more formal therapeutic support such as the arts therapies are offered to the person receiving day care. When day care is no longer an option the person may have to move into community NHS, voluntary or private residential care or alternatively be assessed in the local hospital. Arts therapists work in all these settings.

- The NSF (2001) for older people advocates the delivery of "person-centred" care and the end of ageist discriminatory practice. This report led to calls for more accountability and transparency in the delivery and provision of local health services for older people. In the NHS there is currently a drive for evidence-based practice. The hierarchy of evidence that underpins the EBP model places randomised control trials as the preferred research methodology while expert statement is situated in last place. Gilroy (2006) argues that such expert opinion should be given more recognition. She suggests that there is a need for art(s) therapists to develop their own levels of evidence, evidence that reflects the predominance, in the art(s) therapy literature, of case study descriptions of in-session practice. Quality Improvement Scotland (2005) advocates the development of Best Practice Statements. These are statements gathered from professionals working in the field that are intended to illustrate and guide health care practice. The aim of this study is to develop a set of statements in relation to arts therapy practice with older people who have dementia to take back to practitioners working in the field.

- Despite recent changes person-centred care is the aim but not always the reality, as underpaid and untrained medical/care staff struggle to meet their client's need for sensory stimulation and interaction. Alternative forms of support are required in order to meet the person's needs.

Chapter Three

Psychosocial and Psychotherapeutic Influences

Overview

This chapter begins by considering the paradigm shift that took place in the dementia care setting during the late 1980s. It moves on to outline the therapeutic activities that were introduced into some day and residential care settings in the 1980s. The emergence of activities within the care setting combined with the development in psychosocial care awakened psychotherapists to the potential of psychotherapy firstly with older people and then later with older people with dementia. As primarily non-verbal forms of psychotherapy, the arts therapies emerged as potential providers of therapeutic support for the person in the care setting. The chapter concludes by highlighting the debates surrounding art as activity versus the arts as a therapeutic intervention.

Paradigm shift in the care setting

The move into community care prompted a re-assessment of the existing model of dementia care. Kitwood (1988, 1989, 1990, 1997) wrote that the dominant medical and care paradigms in operation were complicit in maintaining what he believed was a *standard paradigm;* a standardising of medical intervention and care that he asserted dehumanised the person diagnosed with dementia. Kitwood (1997) suggested that treating the person as a *diseased brain* rather than as a *person* perpetuated the myth that the person dies, both cognitively and emotionally once diagnosed with dementia. The person with dementia then moves into the realm of the "unbeing", a place where a "sense of self is undermined" and no account is given of the person's subjective experience of dementia (Kitwood, 1997, p.14). When we no longer have regard for the person a culture of neglect emerges, one in which both the person being cared for and those caring for the person (in terms of their low status job) are undervalued. Rejecting the existing medical and social care models, Kitwood and colleagues (Kitwood, 1988, 1989, 1990, 1997; Kitwood and Bredin, 1992; Kitwood and Benson, 1995) developed a psychosocial approach to

caring for the person; key to the approach were the concepts of *Personhood* and *Positive Person Work* (Appendix A). Kitwood's (1997) ideas were revolutionary but not without their critics. Bender (2003), while agreeing with the underpinning principles of the psychosocial approach is critical of the concept of a new culture of dementia care, believing it to be 'misleading' as it promotes the idea that this new time has arrived when in fact, he observes, controversially, there is limited evidence to suggest that there has been widespread acceptance of these ideas in practice. He suggests that this is inevitable in a society that focuses on "speed and efficiency" (Bender, 2003, p.339). Other writers wonder if the models of Personhood and Positive Person Work are more idealistic than workable. In the nursing literature the term "heroic model" is used when ageing is viewed in such overly positive terms (Reed at al. 2003. p.17). However critical one is of the new culture of dementia care, it is difficult not to credit the work of Kitwood (1997) with bringing awareness to medical/care staff of the psychological and social needs of the person.

Therapeutic activities in the care setting

Changing attitudes towards dementia care brought with them concerns about how the person occupied him/her self in residential care. Often under-stimulated and isolated, older people living in institutional care are prone to the effects of behaviours such as learned helplessness (Seligman, 1975). The person can quickly become dependent on carers unless he/she is kept motivated. Therapeutic activities such as *Reminiscence Therapy, Validation Therapy* and *Resolution Therapy* were introduced to residents in some of the more progressive care settings from the late 1980s onwards (Brooker, 2001). This development was important in terms of the arts therapies because such activities, although distinct, highlighted for the first time the potential of offering therapeutic activities to the person who has dementia. I offer a brief account of three of the most relevant therapeutic activities in terms of the arts therapies.

Robert Butler (1963, 1974), the originator of reminiscence therapy, believed that facilitating a life review with older people, a reminiscence of their life, could help them integrate, or find "a state of peace in old age" (Butler, 1963, p.529). The approach (still in use today) centres around a themed group activity which focuses

on a specific period in time. Props such as newspapers or household objects from the period are used to stimulate discussion and memories of that particular time. The aim of reminiscence therapy is to provide a shared activity, one that values the person's past history and promotes the person's sense of identity. The idea of working with the person's memories is an important aspect of arts therapies' work, although the technique is more organic (memories emerge in response to the art form engagement) and less pre-planned in the arts therapies sessions. Validation therapy, pioneered by Naomi Feil between 1963 and 1980 brings together techniques from behavioural and psychodynamic therapy. Initially not envisaged for older people with dementia but rather for use with more functional elderly, validation therapy in recent years has been widely used with people who have dementia (Neal and Barton, 1999). The therapy is based around accepting the person's reality as he/she experiences it through a series of validating techniques. Validation therapy shares much in common with the principles of person-centred therapy (Brooker, 2001), as does resolution therapy. "Resolution therapy develops aspects of validation therapy, adopting a less structured, more psychodynamic and individualistic approach" Woodrow (1998, p.247). Carers are encouraged to listen for the hidden meanings behind the verbal and non-verbal responses the person makes and to respond to these (Cheston,1997).

Critics of all three therapeutic activities point to the lack of empirical evidence (randomised control trials) supporting their validity (Woodrow et al. 1998; Neal and Barton, 1999).

Psychotherapy and the older person

Psychotherapists such as arts therapists are concerned with the psychological and emotional impact that issues such as a move into care or loss of a significant other may have upon their clients.

Psychotherapy is an umbrella term for a variety of different psychological therapies, such as person-centred and psychodynamic approaches. Principles from both these approaches inform, to varying degrees, UK arts therapy practice (Karkou, 1998). The aims of Personhood and Positive Person Work are therefore aligned with those of the arts therapists, as we will see during the course of this study. In

fact the move towards person-centred dementia care awoke psychotherapists to the potential of working psychotherapeutically with the older person. Historically, little psychotherapeutic work had been undertaken with this client group. It was not until the 1950s that psychotherapy was considered appropriate for the older person (Johnson, 1985) and only within the last twenty years for the older person who has dementia.

> "Psychotherapy was initially considered to be of little value to the elderly, whose rigidity and interpersonal withdrawal supposedly interfered with the development of insight, and thus personality change"
>
> (Johnson, 1985, p.110).

Hepple (2004, p.371) believes that, "ageism and the predominance of models of psychological development related to children and younger adults" resulted in the lack of theoretical and practice implementation of formal psychotherapeutic services in the UK for older people. One reason for this has been what the writer termed the "therapeutic nihilism" or detrimental consequence of Freud's (1904) pessimistic views on working with anyone over the age of fifty. Such views, according to Lakin (1988, p.44) have led to the "widely shared assumption (in the profession) that the aged are rigid and cannot voluntarily change themselves psychologically." The idea that change is not possible upholds the notion that the therapist working with the older person is engaged in an increasingly dependent relationship, one that lacks curability and the ability for in-depth insight.

General attitudes towards therapeutic work with older people slowly began to change with the development of Jung's (1978) concept of *Individuation* and Erikson's (1963) model of the Life Cycle. Jung (1978) was one of the first psychoanalysts to write about the lifespan from birth to death. In Jung's (1978) beautiful sun analogy the four stages of life (childhood, maturity, middle age and old age) are represented by the daily course of the sun. At sunset the process of individuation (coming to terms with the life that has been led) occurs, during which time the person is asked to accept the polarities of 'good' and 'bad' that exist within him/her. In a similar but less poetic vein the psychoanalyst and developmental psychologist Erikson (1963) suggested that conflicts and stages of development were not just restricted to the childhood years but continued throughout the life cycle. At the heart of the model lies the struggle faced by many older people, to

remain “syntonic”; active and engaged, instead of becoming *dystonic*; disconnected and disengaged (Shore, 1997, p.172).

The person who has dementia may experience some of the most significant life changes following diagnosis, changes such as cognitive and physical decline, loss of familiar people and places, accompanied, for many, by an eventual move into residential care (Wilson, 1997). Miesen (1999), the prolific psychogerontologist, suggested that the move into care and subsequent loss of a significant attachment figure (e.g. partner) can be traumatic for the person. In his research Miesen (1999) studied the impact of this loss on the person with dementia. He found that in order to compensate for the loss of the significant attachment figure the person might again (as he/she did in childhood) become orientated to his/her parents (parent orientation). As the person’s dementia progresses and he/she becomes more confused and anxious, the person can become fixated on finding his/her parents (parent fixation). For example, the person may constantly speak about his/her parents and often make attempts to go and see them. Miesen (1999) believes that parent fixation happens because the person feels so disconnected from the cognitive, physical and environmental changes that are happening around him/her that an incredible sense of fear is evoked which, if not addressed, leads to the person withdrawing from the world. In order to counteract this state the person needs to find an attachment substitute, someone who will spend regular quality time with the person.

Loss is often cited as one of the most significant of the emotions experienced by the person, however, there are many more. The art therapists Wilks and Byers (1992) write of the denial that a person may experience as he/she struggles to come to terms with the diagnosis. As the disease progresses the person may feel agitated, frustrated, sad and angry (Kelleher, 2001) as the world around him/her seems confusing. Raijmaekers (2007) comments that the person’s defence mechanism may propel him/her into a state of regression. Regression typically occurs when the person feels disempowered, feels that he/she no longer has control over life. In the care setting this may lead to a state of *learned helplessness* (Seligman, 1975) as the person no longer feels able to make choices because all the choices concerning him/her are being made by other people. Eventually this can create a cycle of dependency when the person feels so helpless that the only option is to withdraw

from the situation (Wilks and Byers, 1992). When the person is no longer viewed as a productive member of society the person may become socially dead, doomed to live what Burgess (1960, p.10) refers to as a "roleless role."

In the care setting medical/care staff do not always have time to listen to the person; they are too busy looking after the day-to-day needs of the person. Staff can often become numb to the impact of the care setting on the person. According to Waller (2002, p.7) a culture of hopelessness can emerge in care settings where staff become reactive, acting in a "manic, overly positive" way which leaves no room for clients to express any independent emotions in case of contravening the "happy" care environment. Waller (2002) believes that unless care staff are trained to understand their feelings and the strong emotional responses of their clients then there is a danger that they will continually deny the feelings of their clients. In my masters dissertation (2003) I noted that Kitwood (1997) also acknowledged the importance of the therapeutic relationship. He felt that the therapeutic relationship had the potential to offer the person a different kind of relationship, "one that is more tolerating, accepting and stable than normal relationships" (Kitwood, 1997, p.98). He commented that through the relationship the person with dementia may feel a sense of self worth, and through involvement in a different type of relationship the person can learn "new action schemata" which can be transferred to other relationships, in other contexts (Kitwood, 1997, p.98).

Role of the psychotherapist

Psychotherapy with a person who has a progressive illness is distinct from other types of client therapy work. Kitwood (1997, p.99) observed that for a person who has dementia "therapeutic change can endure but there is no point at which therapeutic work is done." He suggests that the person requires the constant replenishment of the six psychological concepts of Personhood. Garner (2004) has written that psychodynamically orientated psychotherapists have to adapt practice to suit the needs of the person. She notes that in verbal psychotherapy the psychotherapist might take on the role of narrator, helping the person to remember the stories and words that they have used. Empathetic listening is an important part of the work because through listening attentively to the person symbolic and metaphorical themes may emerge from the stories that he/she tells which may direct the therapist to how the person is feeling (Casson, 1994). Through these

stories the person can maintain a sense of identity, remember him/her self as an active person who coped with situations in certain ways.

The US group psychotherapist Lakin (1988) suggests that psychotherapists need to pay attention to the physical and psychological capabilities of their clients by offering them shorter but more regular sessions. The writer notes that in assessing the person for therapy psychotherapists need to consider if individual or group therapy would be more beneficial. He considers that individual therapy is more appropriate for clients "who require a great deal of personal support, who are excessively fearful or paranoid, or for those whose communication abilities are greatly impaired" (Lakin, 1988, p.47). Lakin (1988) comments on the importance of group work in providing important social connections which enable the often isolated person to remain socially involved with a group of like minded people. Linden (1953) agrees that the person can be lifted out of his/her isolation by taking part in the group, but only if it is a group in which the person feels motivated and happy to participate. Within the group or individual context the psychodynamic psychotherapist adopts a non-directive approach and tries not to lead or direct the session. The assumption is that the more directive the therapist is the more he/she rather than the client dominates the session. The role of the therapist is to provide a secure and supportive environment in which the client can work through his/her issues. The degree to which therapy sessions with older people are in fact non-directive is a source of great debate.

Important considerations for the psychodynamic psychotherapists are the issues of transference and countertransference. Hepple (2004) discusses how often transference dynamic is overlooked by psychotherapists when they work with older clients, particularly those who have dementia.

> "To overlook the possibility for transference, to neglect the memory traces of adult sexuality, to disregard the vestiges of a former reasoning, judicious, and responsible ego, denies any therapy the goal of personality rehabilitation and reintegration" (Hepple, 2004, p.155).

In the transference relationship the psychotherapist is forced to confront his/her feelings about death and mortality (Johnson et al. 1992). The psychotherapist's feelings may mirror those experienced by his/her client, feelings such as loss,

helplessness and anger (Wilks and Byers 1992; Smith, 2004). Wilks and Byers (1992) comment on the complexity of the countertransference.

> "It is often hard to keep aware of the value of the work. Our clients convey a sense of futility and helplessness which makes us feel helpless in countertransference. I think that this is one reason why the care of elderly people with severe memory loss is often seen by professionals as one of the least attractive areas of work" (Wilks and Byers, 1992, p.95).

Not only feelings of futility and helplessness may be encountered in the transference dynamic but also alternatively, feelings of love may be evoked as the relationship mirrors other positive relationships. Wadeson (2000) comments on the deep sense of attachment and love the therapist may feel towards his/her "grandparent". Linden (1953) notes that another issue of working with older clients is the tendency for the therapist to infantilise the client. The dangers in doing this are that the child is in a state of dependency waiting for the development of independence, while the older person has already led an independent life and is now in a state of forced, or "hostile, but anxious and fearful" dependency as a consequence of the degenerative disease (Linden, 1953, p.155). The person needs support from a not too controlling therapist, otherwise dormant infantile patterns, related to dependency, may be re-awakened.

> "(The person can be) reinstated to a degree of independence only when the authority progressively divests himself of authority, removes from himself the fiction of omnipotence, and gradually levels himself toward an area of mutuality with the patient" (Linden, 1953, p.155).

Unterbach (1994, p.40) believes the role of the therapist was to "support the ego, functioning as an auxiliary ego." Saul (1988, p.198) comments that successful therapeutic alliance occurs when the therapist provides "supportive and compassionate leadership." Supporting the person is the primary role of the psychodynamic psychotherapist. However, one issue that arises for verbal psychotherapists is the time-limited nature of the support they can offer the person in the face of their client's deteriorating linguistic skills.

The arts in the care setting

Awareness of the need for non-verbal psychological interventions, combined with anecdotal evidence of the benefits of therapeutic activities in the care setting, led in the 1990s to interest in the arts and then the arts therapies. Historically, arts type activities were available to a select few psychotic patients, including those with senile dementia, in the asylums of the 1860s and onwards until the close of the large psychiatric hospitals in the 1980s (Skailes, 1997; Waller, 2002). During the paradigm shift in dementia care writers and researchers realised that in order for the person to share his/her experience of dementia alternative forms of communication were needed (Goldsmith, 1996; Killick and Allan, 2001; Alan 2002, Hubbard et al. 2002). Unterbach (1994) has written that communication remains with a dementia sufferer throughout his/her life; it is only the person's ability to communicate (in the singular verbal way that society demands) that deteriorates. Engaging in the arts was viewed as one way that could offer the person an alternative means of communication (Kitwood and Benson, 1995; Killick and Allan, 1999; Killick and Allan, 2001).

Two key people advocating the employment of the arts with people who have dementia are the writer and poet John Killick and his professional partner, the psychologist Kate Allan. They began to explore the theme of communication and the arts in their collaborative writing (1999, 2001). Killick would go into nursing homes and write down what he heard people say, creating poems from their words. These poems are highly regarded by professionals working in the field because they offered a window into the person's experience of dementia.

Arts as activity or therapy?

Killick and Allan (2001, p.20) wrote that: "Increasing numbers of people are becoming aware of the possibility of bringing arts activities to people with dementia, this chimes with the widespread awakening to issues around personhood, dignity and communication." They believed that engagement in an artistic activity "can play a crucial role in self-esteem confidence, quality of life and communication" (Killick and Allan, 2001, p.20).

Both writers have commented on the diverse range of arts activities that are taking place in care settings today. One look at the index in the *Journal of Dementia Care* under the *'arts use of'* section lists over a hundred articles written by nurses, carers and arts therapists, all of whom are working on different types of arts projects. Other projects include *The Elderflowers* run by Hearts and Minds, which is a group of professional performing artists specialising in working with people with dementia. They use clowning as an art form (wearing old fashioned clothes, red noses) to engage the person in playful interaction. Killick and Allan (2001) define these arts activities as *informal,* as opposed to the arts therapies which they define as *formal therapy.* In their 1999 paper the writers are critical of these formal arts therapies. The writers believe that a power dynamic is created in the arts therapy session in which "one party act(s) in an expert role" (Killick and Allan, 2001, p.18). They disapprove of the "more consciously designed interventions" employed by US art therapists like Kahn-Denis (1997) and Annette Shore (1997) who they consider have framed their work around "hardlined medical and stage models of dementia" (Killick and Allan, 2001, p.18). The writers do acknowledge, however, that trends are different in UK AT but that the lack of systematic writing and research about UK practice makes it unclear what distinctions exist in practice.

Chapter summary

- Kitwood and colleagues (Kitwood, 1988, 1989, 1990, 1997; Kitwood and Bredin, 1992; Kitwood and Benson, 1995) considered that the biomedically dominated medical and care models standarised the type of care the person received and took no account of the person's subjective experience of dementia. Critics suggested that Kitwood's (1997) model was too idealistic and viewed dementia in overly positive terms.

- During the 1980s therapeutic activities were available in a few care settings. The introduction of these therapeutic activities in the care setting as well as the move towards more person-centred dementia care awoke psychotherapists to the potential that psychotherapeutic work with older people who have dementia was possible.

- Psychotherapists can offer the person a different kind of relationship from that of the medical/care staff worker. Psychotherapists are trained to listen attentively to the person, to hear the symbolic and metaphorical themes that emerge from the stories that the client tells the therapist. The therapist aims to support the client, to help him/her with ego strengthening
- The verbal psychotherapist may act in the role of narrator helping the person to remember the stories and words that he/she uses. However, when the person's verbal skills deteriorate other non-verbal psychotherapeutic forms of support are required. Increasingly, people have become aware of the arts as source of potential healing. Some debate surrounds the use of informal versus formal arts with this client group. The literature points to a clear lack of understanding about how arts therapists work with this client group.

Chapter Four

Arts Therapies and Older People/Dementia Literature

Overview

In this chapter I offer a chronological review of the pre-1990 (1970 onwards) and post-1990 (until 2007) national and international older people/dementia and arts therapies literature. I use the pre-1990 and post-1990 date as markers to illustrate the development of literature in the field, from writing on the elderly and arts therapies to the more specific arts therapies and dementia writing. The reason for my inclusion of literature from the wider older people and international fields relates to the paucity of UK arts therapies and dementia literature (Waller, 2002; Odell-Miller, 1995) both in terms of empirical research and in terms of descriptive accounts of individual practice and theory development. In line with the principles of mapping, the literature review was primarily concerned with documenting the searched for and gathered accounts of arts therapies practice. The bringing together of this widely dispersed and fragmented body of literature was a major undertaking which involved a global search to locate the relevant papers.

Tables are used in the post-1990 section of the chapter to highlight the most recent UK/European research.

Pre-1990 arts therapies and older people literature

Art Therapy (AT)

AT is the largest of the four UK arts therapies and like all the arts therapies writing in this field emerged later than literature on other client groups.

In Byers (1998) review of literature she noted that early writing in the field stemmed from north America and focused on evidencing the benefits of AT for older clients.

For example, Dewdney (1973), Weber (1981) and Wald (1983) wrote about the value of art in encouraging “a stronger sense of identity in their elderly patients, and (helping) improve self-esteem and socialisation” (Byers, 1998, p.110). Zeiger (1976) discussed the potential for art to unlock suppressed memories, the image acting as a symbolic container for the person’s conscious and unconscious memories. Morrin (1988, p.245) wrote about the potential of art to “release and relief (clients) from tension.” Morrin (1988, p.245) in discussing who AT is for, noted that AT was suitable for individual client’s or alternatively it could be undertaken with a group where, the sharing of artistic creativity could engage participants in "spontaneous patterns of interaction with the therapist and other members of the group” (Morrin, 1988, p.245).

In terms of approach, the US literature has focused on a directive (a structured or themed) rather than non-directive (a non-structured or themed) intervention. Dewdney (1973) described her directive approach to AT as a way of working that employed ability related techniques or activities. Techniques such as drawing and colouring an object from observation or picture completion; during such activities Dewdney (1973) envisaged that the art therapist might engage the patient in discussion about past memories or current issues relating to events in the hospital.

The UK AT literature points to a less directive intervention, an approach more aligned to that of Rugh (1985) who adopted an experiential process orientated rather than directive approach. Art therapists writing in the UK literature do not write about the techniques and activities used in the session but instead focus on discussing the triadic relational interaction between client, therapist and image. The reason why the focus in UK and US writing was different was connected with the newness of the work and the distinct traditions that underpinned the models of practice is each country. The prolific US writer Judith Wald (1983, 1986, 1989) reminds us that AT work should be “supportive rather than curative” (Wald, 1989, p.215). The art therapist, therefore, engages in strengthening the person’s ego (providing a secure base through empathetic support) rather than making insight-orientated observations that address a specific behaviour. Interestingly, Wald’s (1989, p.215) observation about AT being “supportive” rather than “curative” is not discussed in the UK or international AT literature. One reason for this is that perhaps there is a perception among art therapists that supporting a person rather

than ‘curing’ him/her is somehow less therapeutic? This may link into general feelings about working with the elderly.

The primary focus of Wald’s (1983, 1986, 1989) work has been on developing an assessment model that uses the image as a diagnostic tool. Wald (1989) wrote that image has the potential to determine the person’s changing cognitive and emotional state. For example, in session, Wald (1989) would ask the person to draw certain familiar images such as a house, a face or other such familiar objects in order to determine the person’s “visual perception and capacity for processing sensory input, translating it and organising ideas into a graphic modality” (Wald, 1989, p.207). Wald’s (1983) diagnostic model was popular among US art therapists but was not widely discussed in the UK AT literature. The only reference to writing on assessment by a UK art therapist was Rita Simon’s (1985) paper on *Graphic Style and Therapeutic Change in Geriatric Patients* published in the American Journal of Art Therapy. Simon (1985) traced the changing graphic style of her clients’ images as they attended AT. She believed that this method had the potential to be used as an assessment tool, however, her model was not adopted into UK practice. Two reasons may account for this; the first was that UK writing during this period had newly begun to explore the potential benefits of art therapy with this client group and, as such, no specific areas of practice had been fully identified. The second reason was that both approaches offered a standardising of the image and of AT processes which was at odds with much of the process-orientated practice happening in the UK.

Early UK writing was concerned less with arts technique and more with how AT could help the person process issues impacting upon him/her; in particular issues relating to death and dying. Rita Simon (1981) and later Miller (1984) both wrote about end of life issues. Both writers were particularly interested in how the image could be a conduit for symbolic expression of feelings around death and dying (Byers, 1998). Simon’s (1981) work focused on what she termed *bereavement art*. Bereavement art was created by a person experiencing feelings of loss, related to self-loss or loss of significant other. She suggested that bereavement art was best worked through in the “companionship and security of a therapeutic relationship” (Simon, 1981, p.135).

In a later paper, Miller (1984) wrote about the 'taboo' subject of death that pervades our society and how we inhibit people, particularly older people and the terminally ill, from coming to terms with death. Miller (1984) suggested that image making could help clients to visually communicate their feelings about death. Images can "cope with the expression of the infinite and oblique" that verbal language cannot (Miller,1984, p.132). The reason for this, suggested Miller (1984), was that visual understanding happened on many different levels; images contained many layers of symbolic meaning that needed to be peeled away or left unpeeled.

Byers (1998) observed that from the late 1980s worldwide literature focused more on the psychodynamic transference relationship. Writing in the *Canadian Art Therapy Journal* by Shore (1989) focused on the complexity of the transference relationship that the art therapist may experience when he/she works with older clients. Towards the end of the 1980s art therapists began to write more specifically about working with cognitively impaired older clients (Byers, 1998).

Music Therapy (MT)

Pre-1990 MT literature is limited. Odell-Miller (1995, 1995, 2002) observed that music therapists tended generally not to work in this field. Odell-Miller's (1995) review of all published accounts of MT with the elderly pre-1996 revealed the paucity worldwide of MT research. She found that between 1969 and 1986 only four articles had been published in this area.

Early writing had come from two Australian music therapists, Bright (1972) and Allen (1977, 1979). Bright (1972) described her use of music in movement sessions with her geriatric clients and also about the importance of music as a tool for emotional expression and re-socialisation (Bright, 1972). Allen (1979, p.7) wrote about "engaging groups in singing and playing percussion instruments." Towse (1995) considered Allen's (1979) work to be about a remedial type of music activity distinct from what she perceived modern MT was concerned with, namely, facilitating the client's exploration and acceptance of feelings and "… using music to encourage catharsis" (Towse, 1995, p.327).

It was not until the 1980s that any MT with the elderly writing was published in the UK. Odell-Miller (1995) decided to address the lack of research in the field by undertaking her own study in the 1980s, written up in 1995. She undertook a two-part quasi-control trial study looking at the effectiveness of MT compared with Reminiscence Therapy (RT). The aim of the study was to investigate how effective MT was compared with RT at achieving observable change in behaviour during and after group sessions. Her study concluded that.

1. Participation levels were higher in MT than RT.
2. MT clients showed more engagement half an hour post the session than clients attending RT.
3. Clients' participation levels were higher when they had regular music therapy sessions.

The first and second findings, although not significant, did illustrate to Odell-Miller (1995) that MT had an important place in older people's health services. Odell-Miller's (1995) research was important because it was a starting point for research in this area. Some questions could be asked about the application of her pre and post control trial methods and how fully the data was analysed. For example, she does not offer a detailed explanation of the measures that she used. Interestingly, following this research Odell-Miller (1995) felt that such quasi-control trial studies were not the most appropriate research methodology for uncovering the effects of MT on older people, instead she concluded that more qualitative case study type research should be undertaken. David Aldridge (2000) like Odell-Miller (1995) also felt that the case study approach better captured the nuances and subjective experiences of both client and therapist.

Dramatherapy/Drama Therapy (DT)

It was not until the 1980s that any UK published literature appeared on DT with older people (Langley, 1983). In attempting to advance a theoretical framework for DT with older people, Gordon Langley (1983) advocated that clinicians and dramatherapists work within a common framework of Maslow's hierarchy of human needs. He advocated Maslow's hierarchy for two reasons, the first being a desire to see a change in the cure versus care model towards a more cure versus

personal growth continuum. His second reason was to encourage dramatherapists to better assess and evaluate their therapy work. Langley's (1983) idea of integrating Maslow's model into DT practice has not been widely commented upon by dramatherapists in the field. In fact, Langley's (1983) writing was the only UK writing I could find that proposed any theoretical framework for the work.

In later writing, Dorothy Langley (1987), identified three broad aims of DT with older people:

- "Enrichment of life: the intention is to improve the quality of life of the client and engender a sense of play through creativity.
- Goal-specific learning; social skills, rehabilitation and assertiveness can all be stimulated through drama.
- Psychotherapy, psychodrama, sociodrama and dramatherapy are all ways in which neurotic conflicts may be resolved and resolutions concerning various endings can be achieved" (Langley, 1987, p.236).

In discussing "enrichment of life" Langley (1987, p.236) pointed to DT bringing value, meaning and fun to older peoples lives. She believed that DT could help to counteract the effects of institutionalisation by offering a non-conforming activity, one in which the person is free to explore his/her creative potential. In terms of "goal-specific learning", Langley (1987, p.236) noted that social skills can be maintained through their rehearsal in the drama activity. Regarding the therapeutic side of DT, Langley (1987) considered the person's need to come to terms with unresolved conflicts. She believed that through 'dramatic enactment', enacting a feeling or emotion through role play for example, the person is provided with a non-verbal, symbolic way of processing painful and often unspeakable feelings related to their own mortality. This is similar to a person creating an image, playing an instrument or making a movement.

Langley's (1987) approach integrated drama methods with techniques from reality orientation and reminiscence theatre (Langley and Kershaw, 1982). In group sessions Langley (1987) used methods from reality orientation to orientate the person to time and place, spatial awareness, the senses and personal identity and

social skills. Clothes and dressing up activities were used to engage the person's interest in their personal appearance. Social skills were maintained by encouraging group members to go round the room and greet other group members. A particular interest of Langley's (1987) was the use of methods from reminiscence theatre in her sessions. The version of reminiscence theatre that Langley and Kershaw (1982) established centred around the use of music hall skills and story improvisation. In line with the music hall tradition, songs and music from particular periods were sung and played to a group who would then join in. In terms of story improvisation, stories would be collected from residents in residential care and the company that Langley (1987) performed with would then improvise scenes from the stories and perform them back to the residents. The aim with these sessions was to allow the person to see him/her self in a time where he/she coped with life and had fun. In seeing him/her self this way the person could feel motivated to activate old coping strategies to help him/her cope with the current situation. In reading the DT literature I formed an impression that the aims of DT identified by Langley (1987) were shared by other dramatherapists but that Langley's (1987) particular approach had not been widely adopted by other dramatherapists. I think the reason why was because much of the early writing sits in isolation in the sense that published accounts of practice were not followed up with debate from within the field because there were so few practising dramatherapists. It will be interesting to learn if any of her techniques are used by the dramatherapists interviewed in this thesis.

The most prolific US writer in DT, David Read Johnson (1985, 1986, 1987), noted that early DT writing from the US and UK portrayed drama therapy as an activity rather than therapeutic intervention (Berger, 1981; Michaels, 1981; Thurman and Piggins, 1982; Weisberg and Wilder, 1985; Ziemba, 1985). The reason for this stemmed from an ongoing debate within related fields such as creative drama, a form of drama improvisation, about therapeutic versus artistic goals of the work (Davis, 1987). Johnson (1987) commented that it was not until Feil's (1981) work on validation therapy, Jennings' (1973), writing on remedial drama and his own later work (1985, 1986, 1987) pioneering the *developmental method* that a set of coherent approaches underpinned by theoretical knowledge emerged to inform DT practice. Johnson (1986), in fact, was one of the first writers to create a psychotherapeutic drama therapy model for older people with cognitive (mild

confusion) and physical impairments. His developmental model was aimed at creating "meaningful interpersonal relationships amongst group members" (Johnson,1986, p.17).

In his 1985 paper on *Expressive Group Psychotherapy with the Elderly*, Johnson advocated that "insight-orientated group psychotherapy using the symbolic and the nonverbal medium of creative drama" could benefit cognitively impaired older people by offering them *concretization* (bringing into form of present unconscious feelings through improvisational enactments), *simplification* (role-play, taking the person outside of him/her self, suspending the need for social norms) and symbolization (the transitional space creates a place for free-play – internal and external states are symbolised through play which have the potential to be connected to past attachment figures and current transference relationships). Johnson (1985) felt that his group gained insight into anxiety-making issues through the use of play and metaphor, role-play, reminiscence and re-enactment of previous relationships. Johnson's (1985) developmental method is frequently cited in the US DT literature but interestingly his work is not widely referenced in the UK literature. One reason for this may be that the notion of an insight-orientated model challenges the DT (and wider arts therapies) field assumptions about the type of intervention that is offered to older people. Wald's (1989) suggestion that such work is supportive rather than curative is at odds with Johnson's (1985) perspective. It will be interesting to learn if the dramatherapists interviewed in this study employ such an insight-orientated model in their practice.

Dance Movement Therapy/ Dance Therapy (DMT)

DMT is the youngest of the UK arts therapies. Stockley (1992) commented that little has been published in the UK on DMT with older people although more was written in the US on dance therapy, the US equivalent of DMT. Sandel (1978, 1987, 1992), the most prolific US writer in the field, pioneered a movement therapy course in the 1970s at the Sound View Specialised Care Centre in West Haven. The programme was set up in response to a growing awareness that product-orientated activities served little purpose for people with diminishing skills. Instead Sandel (1978) set about creating a more process-orientated group intervention, one that was framed round "empathic improvised movement" (Stockley,1992, p.85). Her approach incorporated the use of movement, music,

touch and vocalizations in sessions. Key to Sandel's (1978) approach was working with the memories that emerged from the person's movement patterns. Sandel (1978) believed that reconnecting the person, via the movement, to memories had the potential to connect the person to his/her early life experiences and that this in turn could link the person to the present context and perhaps an understanding of how he/she was currently feeling.

Sandel's (1978) idea that the person's memories could be stimulated through his/her movement patterns signalled for the first time that the person could potentially engage in improvised or free movement. Exploring this idea further, Caplow-Lindner et al. (1979) noted that the primary role of the dance movement therapist was to stimulate constructive recall or to help the person engage via movement activities in structured remembering. The writers suggested that the role of the dance movement therapist was to promote a freer relationship between the body and the mind of the person he/she was working with.

Sandel (1978) and Caplow-Lindner et al's (1979) work was pivotal in awakening non-DMT practitioners to the potential of dance being used in a therapeutic context. In later publications Fersch (1980) and Caplow-Lindner et al. (1979) described the benefits of DMT with older people. Fersch (1980, p.33) wrote that DMT was a "holistic approach", one that "act(s) as a motivating force for maximizing lifelong growth potential." Fersch (1980) identified the DMT potential as one that engaged not only the physical body, mobilising underused body parts, but also engaged with the person's psychological process of self-awareness. She believed that through engagement in DMT the person could develop "a realistic body image, one that provided "a physical basis for identity" (Fersch, 1980, p.34). Moreover, she suggested that the 'here and now' movement facilitated "an authentic experience of action in the present (which) reinforces the ability of the elderly to take initiative" (Fersch, 1980, p.35). As well as the above benefits, Fersch (1980) suggested that DMT had the potential to revitalise the person's capacity to think. The mind and body become connected through the stimuli of "movement themes and improvisation" (Levy, 2005, p.230).

Caplow-Lindner (1982) considered DMT of value to the older person because of its multiplicity. In the DMT session the client is brought into a physical, social, non-

verbal as well as playful sense of self. She suggested that, “the range of dance movement possible during a therapy session is a continuum, from energetic and freely initiated actions to passive motion such as assisted arm swinging or rocking” (Caplow-Lindner, 1982, p.168). The therapist works to bring “specific expressions” from the symbolic movements made by his/her group (Caplow-Lindner, 1982, p.173).

In 1988, Samberg wrote that DMT now had a “place in our culture as an important means of communication” (Samberg, 1988, p.235). In her paper on communication Samberg (1988) noted that rhythm and moving the body in a rhythmical way could communicate the emotional state of the person and help to ease his/her emotional and physical pain. She suggested that touch could be used as a “primary means of communication” (Samberg, 1988, p.236), by touch Samberg (1988) meant holding hands, massaging hands and shoulders. Communication could also be established through mirroring; movements could be mirrored by the therapist to the group or by a member of the group to the rest of the group. Samberg (1988) observed that DMT was about the small as well as the whole body movements.

Samberg (1988) wrote that even the smallest movement is useful for disengaging the person from the inertia of the care setting, where people sit for long periods without moving. In session she described using breathing and relaxation techniques. In writing about the role of the therapist in session, she discussed the concomitant need for the therapist to provide both structure and flexibility, in terms of providing a structured activity as well as flexibility in the form of facilitating the person’s ability to improvise a movement. Samberg’s (1988) observation about the concomitant need for the therapist to offer both structure and flexibility offers a more developed understanding of the role of the dance movement therapist in session.

Summary of pre-1990 literature

- The pre-1990 literature focused on the development of the arts as a therapeutic intervention instead of an activity. Much of the early arts therapy with older people literature is characterised by individual practitioners ‘testing the waters’, offering clinical descriptions of how they work in practice, describing aspects of their practice, theory building and generally

promoting the field. The writers do not apart from Wald (1989) yet make a clear distinction between arts therapy practice with older people and arts therapy practice with older people who have dementia. An overview of the shared and distinct key concepts in the pre-1990 literature is offered in table three.

- Shared themes emerged in terms of the aims of the arts therapies. These are identified as encouraging self-expression/communication through the art form, socialisation through group interaction, and building self-esteem. In AT, DT and DMT writers comment on their respective art forms' ability to unlock memories, and to provide the person with an outlet for reminiscence. AT and DMT writers discuss the art forms' ability to structure the person. In AT this is achieved through the constancy and sequence of the images (Miller, 1984), while in DMT through improvised movement. DMT and DT writers comment on the importance of adult play.

- Distinctions exist in terms of the different art form modalities. Art therapists have written about bereavement art. Music therapists have written about the cathartic nature of music. In drama the focus has been on integrating DT practice with reminiscence therapy and theatre approaches. In DMT the focus has been on engaging the clients in movement, vocalisation and breathing/relaxation exercises.

- In theoretical terms Langley (1983) discussed integrating Maslow's model into DT practice. Langley (1987) discussed the integration of techniques from reality orientation and reminiscence theatre into DT practice. Johnson pioneered a new developmental method to group therapy (1985, 1986). In the AT literature the dynamics of the transference relationship are discussed. Apart from Johnson no writer gives a clear indication of the precise psychotherapeutic, artistic/other theories that underpin the arts therapists practice with older people. One reason for this might be that this knowledge is assumed rather than stated.

Table 3 – Overview of Key Concepts in Pre-1990 Literature

Discipline	Shared Concepts	Distinct Concepts
AT	Goals of therapy Expression/communication Socialisation Identity/esteem Reminiscence Emotional release Theory Psychotherapeutic Transference	Goals of therapy Bereavement art Sequencing Assessment (US) Diagnostic potential of the image
MT	Goals of therapy Expression/communication Emotional release Socialisation Encouraging catharsis	
DT	Goals of therapy Expression/communication Socialisation Self-Identity/esteem Rehabilitation Reminiscence Theory Psychotherapeutic	Theory *Psychodynamic* Develop. Method *Artistic* Reminiscence Theatre Play Role play *Other* Reality orientation Maslow's hierarchy
DMT	Goals of therapy Expression/communication Socialisation Identity/esteem Emotional release Reminiscence Theory Person-centred	Goals of therapy "Stimulation for constructive recall" Touch Vocalisation Breathing/relaxation Improvised movmt.

Post-1990 arts therapies and dementia literature

Waller (2002) observed as late as 2002 that there was a lack of systematic research and published work in the UK arts therapy and dementia field. This has been true of AT, DT and DMT but since 1991 a substantial body of MT and dementia research has emerged from the US. The UK/European literature, like the pre-1990 writing, is characterised by case study descriptions of individual arts therapy practice, although some important UK/European empirical research emerged (this is presented in tables). Writing during this period continued to draw from both national and international sources.

Art Therapy (AT)

Early post-1990 US literature was rooted in behavioural concepts aligned to the biomedical model. Harlan's (1990.p.99) concept of "autonomous functioning", although behavioural in orientation, was considered an important milestone in AT because it marked the beginning of writing pertaining specifically to clients who have dementia. The tenet of Harlan's (1990) writing was that the art therapist could help the person maintain a state of independence for as long as possible. She realised that art therapists could often become overprotective of their older clients in a way that could suppress their independence in the session. Harlan (1990, p.101) suggested that the person's "autonomous functioning" is helped when the art therapist is aware of his/her clients behavioural cues (art therapist is aware of "paradoxical actions", when cue gives the impression of opposite behaviour); treating the person as an adult not a child and understanding that wandering relates to deep felt insecurity rather than aimless action. In her work clients produce "safety" images of "houses, churches… as well as childhood themes and favourite foods" (Harlan, 1990, p.101). She advocated the use of "stimulus" images such as "simple line drawings of shapes that suggest(ed) a number of possibilities for the beginning of a drawing or painting (Harlan, 1990, p.101). Harlan (1990) believed that the person could reach a state of independence from such a base of security.

In terms of the UK literature the focus remained on the therapeutic relationship, in particular on the transference relationship. Wilks and Byers (1992, p.95) believed that the image making offered the person a valuable "third way which dilutes the

intensity of the transference and provides an arena where feelings can knowingly or unknowingly be exposed." The notion that the art form acts as a third element within the therapeutic relationship is a key aspect of arts therapy work.

One example where the focus of both UK and US literature was shared was in regards to the potential of AT to help the person reappraise his/her life. The US writer Shore (1997) suggested that Erikson's Life Cycle model (discussed in chapter three) should frame AT treatment with older people. Shore (1997) observed that many older people in residential care were in a "dystonic" state because isolation and grief overwhelmed them. The person was not given an opportunity to reappraise his/her life. In her case study of a man with AD she began the session by offering him a square piece of paper to act as a stimulus image. Shore (1997), like Harlan (1990), believed that the "stimulus image served to provide the ego support that helped him to organize his thoughts and feelings, despite cognitive damage" (Shore, 1997, p.173). Interestingly, in UK writing Byers (1995) discussed the importance of using everyday objects as image prompts. In her work the objects surrounding the clients became a source of stimulation in the session. She did not offer her clients a direct stimulus as the US art therapists did. In Shore's (1997) session her client drew an image of a man. Shore (1997, p.174) said her client named the image "bravery in all fields – Lt Shore." He said that he was naming the image after her because she was a brave person. Shore (1997) equated his naming of the image with the military act of giving a medal to the younger soldier – an act of appreciation. In doing this she said that; "he shared an important emotional connection and expressed genuine caring" (Shore, 1997, p.174). Shore (1997) felt that AT brought the client out of his dystonic state.

Shore's (1997) article formed part of an important collection of US writing on AT with older people who have dementia, published in the 1997 journal *Art Therapy: Journal of the American Art Therapy Association.* The journal published new empirical research findings and descriptive case study writing by art therapists working in the field. In the volume, Kahn-Denis (1997) suggested that image making was an important tool to aid reminiscence of the person's life story. Kahn-Denis (1997, p.194) believed that the sensory/stimulatory nature of the art materials "bypasses cognition" and enabled clients with cognitive impairments to engage in a sensory re-telling of their life story via the image. In her article, Kahn-Denis (1997)

made an interesting observation about AT not being a suitable intervention for some clients because it may create yet another layer of confusion for the person in an already very confusing world. Kahn-Denis (1997) does not expand upon this point so it is left to the reader to question which aspect of AT may create the layer of confusion for the client. Within this context it is interesting to consider how many art therapists employ the stimulus object in session and if this technique has the potential to act as a scaffold or structure which may prevent the person from feeling confused.

Kahn-Denis (1997) and fellow US writer Beaujon-Couch (1997) both highlight the potential for the image to be used as an assessment tool. Kahn-Denis, like Wald (1989) and Simon (1985), was interested in the diagnostic potential of the image. In her work with an eighty-two-year old woman over a two-year period, Kahn-Denis (1997) noted the progressive deterioration of the lines of the heart shape that her client had drawn; the lines had become scattered and fragmented. In Beaujon-Couch's (1997) article she discussed an assessment tool involving Mandala drawings. The thirteen-stage Mari Card Test developed by Joan Kellog categorises Mandala; drawings created by dementia clients. The Mari Card Test developed around Jung's ideas is a psychological test that has identified thirteen base types of Mandala "each structure represents stages of developing awareness or internal processes with an individual, containing both positive and negative aspects" (p.187). Beaujon-Couch (1997) believed that they offered a valuable tool for art therapists to assess the emotional response of their clients.

The diagnostic and assessment potential of image is something that has not been explored in the UK literature. One reason relates to post-Freudian psychodynamic education that underpins UK art therapy training and is distinct from the behavioural model adopted in the US. Another reason was that US writing about the field was more advanced. US writers discussed specific issues relating to practice whereas UK writers were just beginning to describe their work. An example of this distinction is highlighted in Ofra Kamer's (1997) writing.

Ofra Kamer (1997) gave a descriptive account of her work with Steve, a man with AD, in a London day centre. Influenced more by UK than US tradition, Kamar's (1997) sessions with Steve did not begin with a stimulus image, instead Kamar

(1997) started from a more non-directive perspective, inviting Steve to choose an art material to work with. Kamar (1997) reported that Steve rejected all the art materials offered to him and sat watching the rest of the group. Eventually, in one session Kamar (1997) improvised the idea of using a marker pen to create a series of dots on a piece of paper. Steve added to the dots turning them into a creature. Following this, sessions were spent by Kamar (1997) starting off the dots and Steve completing them as a series of creatures. Kamar (1997) said she could only understand what Steve was saying when he talked about the creatures; without the images his language became incomprehensible. Kamar (1997) was concerned that she was encouraging Steve to hallucinate through the drawing of the creatures. As the sessions progressed, Steve added to his vocabulary asking Kamar (1997) to "do it again" in relation to his photocopying of the images for Steve. He even began doing the images at home with the help of his wife. The final session was marked by Steve doing a dot image and writing on it "light and dark" before giving the drawing to Kamar. For Steve the dotted image became an important part of AT. It is interesting to reflect on the introduction of the stimulus dot image into the session. Kamar (1997) began the sessions non-directively but the dot image introduced a directive element in the session, one that provided a stimulus for Steve. What is the distinction between Byers' (1995) use of objects chosen by the clients as a stimulus for art making and Kamar's (1997) decision to offer a direct stimulus image to Steve? It will be interesting to learn if art therapists work more directively with this client group.

Arts Therapy and Progressive Illness – Nameless Dread, edited by Diane Waller (2002) was the first UK book to offer writing from arts therapists working in the field. In the book, the art therapist Tyler (2002) wrote that AT could offer the person a cathartic experience (this idea links back to Towse's (1995) description of modern MT). For Tyler (2002) catharsis comes with the art therapist helping his/her client to come to terms with unresolved conflicts during his/her final years.

Tyler (2002) discussed the way his clients interacted with and used the art materials and how these interactions gave him clues as to what might be concerning them. He suggested that in this way communication is transferred to the freer non-verbal

action. For the client to feel comfortable working in the non-verbal he/she needs to feel safe. This is achieved through the regularity, confidentiality and familiarity of the session, space and therapist.

A further theme emerging from Tyler's (2002) chapter, which is also picked up by Falk (2002) in the same book, is the ability for the image to structure the person to offer him/her "increased control" over his/her life (Tyler, 2002, p.68). In an AT session the person is able to select and use the art materials as he/she chooses, thereby offering him/her "an opportunity to organise their experience in their own way without expectations from others" (Tyler, 2002, p.68). Exploring this issue further, Falk (2002, p.120) writes that the images created can act as a strong "holding-memory" in the sense that week-on-week clients could remember the symbolic images they had created. Falk's (2002, p.120) explanation of this feature of the work was that through their images clients are able to "move from an exterior space that was perceived as muddled and full of dread, to an interior space, over which they had some sense of control."

The notion of the art form 'holding' the person is an interesting idea but critics might point to the fact that this is the subjective observation of one art therapist, working with a small number of clients. Does the notion of "holding memory" (Falk, 2002, p.120) apply to all clients with dementia? Did Falk's (2002) clients remember their images/the process because sessions were structured around a routine? In order to understand Falk's (2002, p.120) concept of "holding memory" a larger number of arts therapists and clients need to articulate their experiences of this phenomenon. This is one area that this study aims to explore further.

The first AT paper to be published in *Dementia: The International Journal of Social Research and Practice* was written by Mottram (2003). In this paper Mottram (2003, p.274) brought to our attention the role of the art therapist and his/her "need for sensitivity" with regards to how art making is perceived by the older generation. Mottram (2003, p.274) observes that to this generation "art materials were a luxury"; art making may have been thought of as a middle class or childish activity that had no relevance to the person. This point of view contrasts with the client who has always longed to work with art materials. Mottram (2003, p.275) commenting on how the art therapist keeps in mind the whole person believes that the therapist

needs to “balance the client’s past, present and future.” Moreover, she reminds us that for many clients this will be the first time that they have shared something of themselves and that the art therapist must not underestimate the many different aspects of the person that she encounters in therapy. Mottram’s (2003) paper is helpful because it engages us in thinking about the generational differences and how therapists must be aware of client’s past and present context.

In 2006 Waller and Sheppard reported on their longitudinal research study into the effectiveness of AT in lowering depression levels among older people who have dementia. The study, funded by the Alzheimer Society and The Health Foundation, ran between 1997 and 2005. The study findings are illustrated in table four.

Table 4 – Research by Waller and Sheppard (2006)

The primary focus of the longitudinal control study was to compare four groups of dementia clients as they participated in AT compared with their participation in four activity groups. The aim of the study was to see if participation in AT lowered levels of depression among this population.

- Phase one ran for nine months and involved twenty-two older people who had dementia (in community or residential care). Phase two followed a year later in which forty-six older people with dementia were selected to join either one of the four art therapy groups or one of the four activity groups. Measures were taken regularly throughout both first and second phases of the study at follow-up periods of one and three months.

- “Findings from this part of the project demonstrated the benefits for participants in the art therapy groups in areas of physical competence, sociability, calmness and mental acuity.”

- The third and final phase of the project involved the analysis of client therapist conversations, therapist session notes and reflections from supervision. The research concluded that, “people do respond to art therapy as there was a decrease in the levels of depression and improved mood among the participants.”

(Waller and Sheppard, 2006, p.7)

Leading on from the research study Waller and Sheppard developed the first *Guidelines for art therapists working with older people with dementia.* Key among these guidelines were:

- Encouraging the therapist to read the relevant dementia literature in order to learn about the person's potential memory and linguistic patterns
- To consider the routine of the setting, how that impacted on therapy work for example when there are changes in a person's routine.
- To keep contact with other medical/care staff to be aware of issues affecting the person.
- To establish an assessment procedure, an appropriate working space, resources in terms of art materials and the therapist's approach in terms of theoretical orientation.
- To consider transference and counter-transference issues. In relation to this to reflect on "quality of life" issues relating to the expectation of the person's abilities. The importance of maintaining professional supervision

(Adapted from Waller and Sheppard, 2006, pp.7-13).

The guidelines offer art therapists a helpful starting point for considering the different aspects of AT with this client group. One potential criticism of the guidelines is that they were written following one longitudinal study in which less than five arts therapists participated. As they currently stand the guidelines are generic in the sense that they could potentially be applied to other client groups (e.g. people with learning disabilities). The view of more art therapists needs to be canvassed for these guidelines to be more representative of how art therapists actually practice with older people who have dementia.

Music Therapy/Music (MT)

MT/music has been the most researched of the arts therapies worldwide in terms of empirical studies. This research has been primarily undertaken in the US (Aldridge, 2000). According to Brotons (2000) the primary reason for the upsurge in research by music therapists and psychologists was as a result of the 1991 US Senate hearing of the Special Committee on Aging, when a large amount of funding was given to researchers to investigate the potential beneficial effects of music/music therapy on managing challenging behaviour and improving the person's quality of

life (using musical interventions to replace drug therapy and the use of restraints). Even today it is still commonplace to see articles in the *Journal of Music Therapy* reporting the effects of music as a form of art on this population, without specific reference to the therapeutic process.

Brotons (2000), a leading researcher in MT with older people, undertook a comprehensive review of all MT/music journal articles, published in English (although no UK writers are represented) between the years 1980–1998. Her research identified eighty-one articles, which included fifty empirical studies and reports (consisting of a mix of descriptive, experimental and case studies), twenty-three theoretical papers focusing on "recommending music techniques as an alternative treatment for a variety of therapeutic objectives" and eight papers on more "anecdotal accounts of music therapy or articles describing non-music objectives" (Brotons, 2000, p.35). Under half (roughly thirty out of eighty-one) of the research was written by music therapists, much of the research reports were undertaken by registered nurses and psychologists. The main findings of Brotons (2000) review suggest that:

- Participation in MT continues across the three stages of dementia.
- "Modelling" (where the therapist demonstrates) by the therapist is an important part of the process.
- Individual and small group sessions are the most valuable.
- "Social and emotional skills including interaction and communication can be enhanced and even improved through live structured music activities."
- Cognitive skills can be improved by the ordered sequencing that music provides. (Brotons, 2000, p.62)

Brotons' (2000) findings suggest that MT is appropriate for people throughout the different stages of dementia. Group and individual work is undertaken and structured (therapist led) activities may benefit the client. In relation to this notion of structured activity Clair (1999, 2000); Tomaino (1993b, 2000); and Ridder and Aldridge (2005) have all written about the benefits of therapeutic singing.

Clair (2000) refers to the shared experience of singing with others, or of singing individually, songs that may awaken memories and lift mood as well as stimulating physical wellbeing through breathing and muscle relaxation. She suggests that the voice acts as a window into the "internal conditions of individuals" and that "therapeutic interventions with the voice can function not only to alter negative or undesirable conditions, but also to maintain, and perhaps further develop positive, desirable conditions" (Clair, 2000, p.89). In relation to the choice of songs, Tomaino (2000) has written of the importance of using songs of personal importance. Such songs, Tomaino (2000) has observed, keep alive the personal memories and stories of the person. In neurological terms Tomaino (1993b, p.197) has noted that the reason why songs and music memory persist in people with dementia is that, "it is the connections of the auditory nerve to key limbic structures in the brain that account for such emotionally charged responses to familiar music." She observed that, "the limbic area of the mid-brain has been indicated in long term memory storage and emotional processing" (Tomaino, 1993b, p.197).

Other US writing has focused on the use of music in behaviour management, for example, to decrease agitation (Lou, 2001; Vink, 2000; Gerdner, 1992) to decrease wandering (Greone, 1993); in mood augmentation, to increase energy levels (Hirokawa, 2004) and reduce depression (Tims, 1999); in improving existing skills, such as using basic rhythmical response to vibrotactile stimulation to maintain concentrated interaction (Clair and Bernstein, 1990a, 1990b). For example, Clair and Bernstein (1995) found that AD clients imitated progressively more complex rhythm patterns over eight weeks/sixteen sessions. Nebes (1992) observed that:

> "The cognitive ability to appreciate music and engage in musical activities appears to be very resistant to most of the neural damage caused by AD. Musical ability utilizes memory (procedural) and perceptual structures that use parts of the brain that remain largely unaffected during the course of the disease" (Nebes, 1992, p.375).

In Tomaino's case study work (2000) with "Molly" and other clients she found that "many seemingly lost memories still exist and can be stimulated with familiar music" (p.209). Clair (2000) found that the elderly clients moved more fluidly and utilised more movements while exercising to live vocal and instrumental music than in exercise with no music. Other research has looked at the benefits of tailor-made or

individualized music (Gerdner, 1997) on the person's participation level, orientation and social interaction (Pollack and Namzi, 1992; Brotons, 2000).

Case study descriptions characterised UK and European (Germany, Denmark and the Netherlands) publications. One example is the single case study by Simpson (2000) of his account of working with Edward an eighty-seven-year-old man with advanced dementia. Simpson (2000) wrote that the first few sessions were framed round him playing a variety of pre-composed old songs which Edward sang. Simpson (2000) described moving out of the structure of the familiar songs in an improvisatory way, from time to time, to see how Edward responded to free-form music. In further sessions the relationship deepened as Edward began to improvise on his own using a drum and a stick to respond to Simpson at the piano. Simpson (2000) noted that as Edward became more comfortable in the music "he became gradually louder, able to imitate simple rhythmical patterns" (Simpson, 2000, p.176). Improvisation, as outlined in the pre-1990 literature is a key concept in MT practice. Simpson (2000, p.176) observed that improvisation gave Edward the freedom to "move out" of the pre-composed structure of the old songs and into a new relationship. Simpson (2000, p.181) viewed the sessions as "space not for cathartic release of habitually experienced feelings and emotions, but for exploration of unpredictable and different ones", a space where Edward could have a "new experience of (himself) and therefore a new experience of life itself."

In a later writing by Darnley-Smith (2002, 2004) she discusses the use of improvised versus pre-composed music. The writer believes that the person's anxiety levels are raised when only improvised music is employed in a session; the reason being that improvised music can be too unstructured for an already confused client group. Commenting on her own practice, Darnley-Smith (2002) notes that her clients required a more integrated approach, one that mediated between improvised and pre-composed musical elements. This is an interesting development in MT terms because it brings to our attention the debate music therapists had with regards to working in a more directive way in the session. This mirrors the debate that art therapists were having about the use of the stimulus object and using a more directive approach.

The notion of structuring the person through music is explored from a different perspective by the Danish music therapist Munk-Madsen (2001). She suggests structure is implicit in live (improvised) music playing. She, like Aldridge (2000), believes that the music therapist's goal is to help the person "build music structure and melodic form through preservation of rhythm and pulse" (Munk-Madsen, 2001, p.20). A "rhythmical and dynamic framework" (p.20) can emerge via the person's engagement with a basic rhythm or pulse (Munk-Madsen, 2001). This has been evidenced by the US writers Clair and Bernstein (1990a, 1990b) in their study of severely regressed older men with dementia. The study found that the older men were still able to participate in rhythmical activities even when they were no longer able to engage in other music activities such as singing. What Munk-Madsen (2001) and Clair and Bernstein (1990a, 1990b) discuss relates to Falk's (2002, p.120) notion of "holding memory" and Sandel's (1978) observations about movement memories and reminiscence. Munk-Madsen (2001) believed that MT provided her clients with a sensory, motivating, structuring and reminiscing type experience that awakened the person's senses and provided a motivating experience for the person.

David Aldridge (1993, 1994, 1995, 1998, 2000) one of the most prolific writers in MT has driven the theoretical debate within the field. He has suggested that MT facilitates communication with people who have dementia. He wrote that "there is innate musicality to human communication", that "the process of living is performance, that we are polyrhythmic, symphonic beings improvised in the moment" (Aldridge, 2000, p.11). Moreover, the writer observed that one of the results of having dementia was that the person is no longer able to "perform" and he/she is lost to the "'now' of (his/her) existence" because he/she becomes dislocated from time and space Aldridge (2000, p.11). He commented that so much of the person's narrative is constructed through his/her "performed identity", the way he/she is viewed in the world. He emphasised the importance of *now* for the person and the role that music (in particular rhythm) could play in scaffolding a time structure for the person, which stimulates the person's memory and the ability to perform in the present. In discussing *time*, Aldridge (2000, p.12) refers to *kairos* rather that chronos or chronological time as we understand it. He states that; "kairos is time considered as the right or opportune moment." In this he means music offers the opportunity for decisiveness; the ability to play music in the

moment, is something that he believes may unlock dementia sufferers from being "prisoners of mechanical time" (Aldridge, 2000, p.12). He warns us that the onus of communication is on society, not on the person with dementia.

In Vink's (2000) study she canvassed the views of other music therapists working in the Netherlands (Table 5).

Table 5 – Research by Vink (2000)

Vink (2000) sent questionnaires to fifty-five music therapists working in general psychogeriatric care in the Netherlands. Thirty-three therapists responded (sixty per cent) to the fifty-seven-item questionnaire asking about their working practice.

- Music therapists identified the aims of the work as helping their clients to establish contact with other people and improve their social skills.

- Therapists undertook both group and individual therapy with clients in the earlier stages of the disease while preferring to work one to one as the disease progressed. A mix of active and receptive music was used with people in the early to mid-stages of AD, while more receptive MT was employed with clients in the later stages.

- Vink (2000, p.138) reported that her research was limited in its "scope of work-related aspects that it addresses." She suggested that other studies could consider: 1) How do therapists decide which techniques to use with a specific population; 2) How do ways of working differ between different older client groups.

Vink's (2000) study is the only one similar to my study that I could find. I was interested in her findings about an integrated directive (particularly with people in the later stages of the disease) and the non-directive approach being used by the music therapists in the Netherlands. Vink et al. (2004) were later involved in the Cochrane Review of MT with people who have dementia (Table 6).

Table 6 – The MT and Dementia Cochrane Review (2004)
• Vink et al. (2004) reported their findings on music therapy with people who have dementia for The Cochrane Review. • The effects of MT in the treatment of "behavioural, social, cognitive and emotional problems" were assessed (Vink et al. 2004, p.2). • The findings of the five RCT studies (Groene, 1993; Lord, 1993; Clark, 1998; Gerdner, 2000) reviewed suggested that because of the poor methodological quality of these studies no valid conclusions could be drawn as to the effectiveness of MT in relation to categories outlined. • The studies reviewed are from the USA. Only Greone (1993) and Gerdner (2000) were actual MT studies. The remaining three were musical interventions. Clark's (1998) randomised control trial study of favourite music during bathing.

In Sherratt et al's (2004. p.9) review of MT literature they found that published MT "focused on the efficacy rather than theoretical frameworks" underpinning MT practice. The writers acknowledged that MT/music writing was published primarily in discipline-specific journals and therefore there was some understanding that theory was implicit.

Despite Sherratt et al's (2004) findings that there was a lack of practice and theoretical debate within the MT field, I did discover that the UK music therapists Moss (2003), Powell (2004) and Wood (2007) had written about these issues. Moss (2003) reported on her evaluation of her MT service. Moss (2003) undertook a six-month evaluation of MT provision in a Medicine for Elderly Unit. The study focused on surveying previous and current MT clients; widening the current service provision by commencing a pilot work in one of the two elderly wards and concluding the project by writing a report at the end of the research period in which future recommendations were made. The study was mixed method and used questionnaires, observations (rating scale analysis) and case studies. Moss' (2003) findings suggest that MT was valued in the setting.

Powell (2004) and Wood (2007) both have written separately about using a community MT model in their work. This is an approach that involves the whole

community within the care setting being involved in the MT session. Sessions take place in an open space within the setting and members of the community (clients, carers and family) join the session when they can. Powell (2004, p177) observed that; “these groups are visible and audible to others in the building, and are inclusive, linking people to the building.” A feature of the work was the performance; a theme emerges from the ongoing MT work in the setting and a performance involving all members of the community is planned. Powell (2004) and Wood’s (2007) work takes MT out of the therapy room and into the wider care setting. It will be interesting to learn if this model has been adopted in practice.

Dramatherapy/Drama Therapy (DT)

The UK literature is characterised by descriptions of therapy work. For example, Paula Crimmens and Alison Kelly (1994) offered their clients performances of stories. They purposely limited the use of props (props are stimulus objects used in DT) in session so as not to over stimulate the client group. They also incorporated real objects in the session. These were used as memory stimulators and as sources of validation. Casson (1994) similarly wrote about his use of props or objects (toy figures, photos, hats) and of music to stimulate the person. The use of props is a feature of DT and DMT practice. Crimmens and Kelly’s (1994) description of using real objects in the session reminded me of Byers (1995) description of using real objects in AT. In her description it is the clients not the art therapist who introduce the objects into the session. It is unclear from Casson (1994) and Crimmens and Kelly’s (1994) articles if they or the clients initiate the introduction of the objects into the DT session.

In Casson’s (1994) article entitled *Flying Towards Neverland* he explores the metaphorical meaning of the person’s spoken words, commenting that often what can seem “nonsense” actually contains meaning and if listened to carefully may give a sense of what the person is feeling (Casson, 1994, p.7). In session Casson (1994) used the conversations of his clients as tools for listening and responding to, for creating a story:

> "Stories can provide metaphors that enable us to make our way through transitional stages. (They enable) us to relate and connect on many levels simultaneously and contain/hold distressing experiences at a safe distance"
> (Casson, 1994, p.7).

The use of the story is a key element in DT work. Crimmens (1998) and Gersie (1997) have both written about the therapeutic story;

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> "Stories perform many functions in creative group work with elderly people. They provide an opportunity for active physical expression, engaging the attention, raising the energy and interest level in the group and allowing alternative role and relationships to be played out" (Crimmens, 1998, p.11)

Stories in DT sessions contain an identifiable character that the person can relate to. In her sessions Crimmens (1998) takes on a directive role as the storyteller but there is a lot of active participation from the clients. Props are used to engage the group.

Wilkinson et al. (1998) undertook the only empirical mixed method research study looking at how clients responded to DT (Table 7).

Table 7 – Research by Wilkinson et al. (1998)

The study used qualitative observations of sessions and pre and post-testing using rating scales; ADAS-cog, MMSE, CAPE, IADL, Cornell Scale for Depression in Dementia and GHQ-12):

- Sixteen clients were placed in one of two groups, a therapy and non-therapy group running over a six-month period.
- Group and individual responses to therapy were very positive, from increased interaction, to humour, to stimulating memory.
- The rating scales, except for ADAS-cog scores, indicated that the initial and follow-up assessments showed no significant difference between the two groups.
- The ADAS-cog score indicated that one of the members of the DT group became depressed. The authors believe that the client's response was not linked specifically to DT. However, they concluded that the quantitative methods were limited in their applicability to illustrate the richness of the in-session interaction.

Harrow (2005) writes of using *devised stories* in her session with AD clients. These are stories that emerge, often in a fragmented way from the memories of her clients. As the client becomes familiar with the sequence of the story he/she begins to remember parts of the story. In this way the story appears, like the image and a piece of music, to hold the memory (Falk, 2002) of the person. Batson (1998) uses a different technique; the initial focus for his story is a large picture in the room from which other stories develop. He says that it can take some time for clients to realise that whatever they say, the story they tell will be accepted. Batson (1998, p.21) believes his role is firstly to offer structure to the story, to ask the person "who are the people in the picture" and "where is the story taking place" and secondly, his role is to remember the story and re-tell it from time to time.

Harrow (2005, p.3) discusses the role of the dramatherapist, noting that, "it is essential for the dramatherapist to have some basic understanding of dramatic techniques (such as) play reading and/or writing, movement, improvisation and maskwork." However, the writer acknowledges that "not all dramatherapists use solely drama techniques" (Harrow, 2005, p.3) although she does not specify what alternative techniques are used. This study intends to find out what techniques or methods are used by the dramatherapists and if these are shared by other practitioners within the discipline? The literature to date suggests that all the arts therapists are working in very individualised ways.

Lev-Aladgem (1999, 2000) discusses the importance of "unofficial ritual" (Lev-Aladgem, 2000, p.316). She suggests that ritual in the day care setting could "germinate the emergence of spontaneous drama and (this in turn would be) transformed back into ritual and vice versa" (p.316). In this way the rituals of the institution are challenged. Influenced by the writing of authors such as Moore and Myerhoff (1977) and Alexander (1988) on "secular rituals" Lev-Aladgem (1999, p.316) writes of her encounter while working in a day care centre with three isolated Iraqi clients. They sat together but did not interact with others. The author began to join them and eat with them. Their meeting became a ritual and then when trust had been established moved into spontaneous drama, with one client miming her actions as she ate while another pretended to sneak some of her food, each encounter building on the previous one.

In a later article Lev-Aladgem (2000) discusses dramatic play. She suggests that it "is one (mono) simple sequence of a symbolic activity. It consists of either using an object as if it were something else, or transforming a given space to an imagined one, or acting out a role" (Lev-Aladgem, 2000, p.6). The writer spent three years in a day centre undertaking participant observations of the daily activities of clients, attending staff meetings, speaking with staff and clients and working actively with the older people as a drama facilitator undertaking a series of different drama type activities focused on dramatic play. In the drama session Lev-Aladgem (2000) moved away from play as a reminiscence type activity, instead seeking to offer clients the "communicative, expressive possibilities of dramatic play that are embedded in the process itself…" (Lev-Aladgem, 2000, p.4). The writer views dramatic play as a lifelong experience, more of "an end in itself" rather than as a "training field" for children (Lev-Aladgem, 2000, p.4). In terms of dramatic play Lev-Aladgem (2000) focuses on using *symbolic activities*. These contain two elements: first the client being *passive* (reporting and observing) and then *active* (describing and using symbolic object). The reflexive aspect is integral to dramatic play.

Knocker (2001) also wrote about play (and metaphor) in DT. Knocker (2001) draws on the work of the occupational therapist Tessa Perrin (1997) to define her understanding of adult play. Knocker (2001, p.5) notes that one aspect of play is that it "counteract(s) the unhelpful effects of institutionalisation." The need to conform to the routine of the setting can leave the person lost, play is a freeing agent because the person re-engages with another side of him/herself. In terms of people with dementia Pulsford et al. (1999, p.16) observe that "play–based activities induce cognitive security (in the sense) that they are more likely to be understandable than more complex stimuli from the adult world." Knocker (2001) comments that the process the art therapist Byers (1995) described in AT writing, where the clients sort, touch and rearrange objects is akin to play, the process used in DT with people who have dementia. Play is potentially an important part of all the arts therapy work but has been most commented on in the DT literature.

In a moving case study by Reinstein (2004) we learn of a less playful side of DT. In his work with Betty and Mary, two elderly women experiencing the later stages of dementia, Reinstein (2004) discusses his own anxieties about undertaking the work as well as the complexities of working with two people who are responding

differently to the illness and in turn to the session. Initially Mary becomes angry and Betty withdraws but as the sessions progress, and as Reinstein (2004) learns of the preferences of his clients, (Mary likes to sing while Betty likes to play an instrument) the three find some group cohesion until Betty's death. Reinstein's (2004) article raises interesting questions about group compatibility and how the person is referred to therapy (this is discussed further in the next chapter).

In the most recent DT publications, Jennings (2005, 2006) has written about the importance of humour for older people. She suggests that humour has the potential to structure the person, to stimulate the person's memory. For example, following a production of Lysistrata (an ancient Greek play in which the women refuse to give their partners sexual favours) the clients were so amused with the play that to the amazement of the staff they remembered it the next day. Jennings (2005) comments that the play was a piece of social theatre. The social theatre model mirrors the community MT model discussed by Powell (2004). It engages with the whole community in the art form. It will be interesting to see if a social or community type model is used by the arts therapists interviewed in this study.

Dance Movement Therapy/Dance Therapy (DMT)

In writing from the US, Sandel and Scott-Hollander (1995) suggest that reminiscence forms an important part of the dance therapy session. In DMT the client can participate in movement reminiscence, acting as a memory through movement. The writers believe that doing this stimulates "cognitive reorganisation" (Sandel and Scott-Hollander, p.136). In this way movement, like the music, the story and the image are used to structure or connect the person to his/her sense of self. Arakawa-Davies (1997) a Japanese dance movement therapist, has also written about movement reminiscence. Arakawa-Davies (1997) writes of movement reminiscence from a cultural context. The narration of culture and passing on of community traditions is an important role for older members of Japanese society. She suggests that DMT is particularly helpful in terms of engaging the person "through the body" rather than through deteriorating verbal language (Arakawa-Davies, 1997, p.293). The body acts as a container, memories emerge through the stimulation of the body via safe activity work and "kinaesthetic awareness" (Arakawa-Davies, 1997, p.293). Memories often emerge spontaneously in DMT

sessions and the memories of a person with dementia may have a fantasy quality that reflects the person's physical and emotional life. Rhythm is used in sessions to awaken memories. Coaten (2001, p.20) wrote that, "memories are stored in the body." During DMT sessions memories are not just awakened through re-enactment but are re-lived in the 'here and now' as the movement acts as "the living symbol of the original event" (Coaten, 2001, p.20). The writer views the person's ability to re-live part of his/her life through movement as a form of giving the person back a sense of self.

Later in her article Arakawa-Davies (1997) offers a first definition of DMT with people who have dementia. She suggests that DMT:

1 "Revitalises bodily movements.
2 Releases psycho-physical tensions and sense of isolation.
3 Stimulates constructive recall, reality contact and social interaction.
4 Provides opportunities for expressing feelings."

(Arakawa-Davies, 1997, p.292)

Arakawa-Davies' (1997) definition is influenced by the work of Samberg (1988) and Sandel (1978). In her article she comments that the role of the therapist is one of guiding the person/group from the "familiar, everyday actions that can be developed and expanded into whole-body movements using both verbal and non-verbal cues" (Arakawa-Davies, 1997, p.293). The UK writers Donald and Hall (1999) suggest that the therapists role within the group is to encourage clients to feel comfortable working with each other, to help construct a group identity, and to support the surfacing of "difficult or significant issues, and resolution" (Donald and Hall, 1999, p.25).

In a later paper by Coaten (2002), the writer discusses care staff joining the DMT sessions. This is the first paper to write about care staff and the arts therapist working together in a session. Coaten (2002) suggests that through helping in DMT sessions staff can learn about non-verbal communication and the spontaneity of moving and dancing.

Marion Violets-Gibson (2000, 2002, 2004), the leading UK DMT practitioner until her untimely death in 2005 (ADAMT, 2005), and Kowarzik (2005) have separately written about their joint work on the Links – Movement and Communication (LMC)

project. Violets-Gibson (2002) worked as the project dance movement therapist while Kowarzik (2005), also a trained DMT therapist, worked as the project researcher. One aim of the project was to provide movement and communication type activities to clients with dementia. The second aim was to give care staff training in using person-centred movement activities with their clients (Kowarzik 2005; Violets-Gibson, 2002). The DMT approach used was developed from Violets-Gibson's work and is influenced by neuroscience, in particular the work of Hannaford (1995) and Demasio (2000). Violets-Gibson (2002, p.20) believed that there was potential to stimulate alternative pathways in the brain of the person with dementia through the employment of the "techniques of play, movement and song in a dynamic and interactive circle." Furthermore, she observed:

> "The procedural memory remains in the musculature of the body and continues 'alive and well', even when the declarative, instructive, factual memory has been damaged. People who have been sitting listless and withdrawn, apparently inaccessible, often with speech difficulties, or who wander incessantly searching for a connection to their lost life, can very swiftly remember who they are once they start to play, sing, chat and dance together in a circle" (Violets-Gibson, 2002, p.20).

In her published works Violets-Gibson (2000, 2002, 2004) describes how she employed an eclectic theoretical approach framed around the interactive movement circle (group participates in a circle dance) model pioneered by Marian Chace (1940). The circle is created using chairs and clients remain seated during sessions. Violets-Gibson (2004) writes that the interactive circle movement is a valuable aid to communication and social wellbeing. The rhythmical movement of these circular dances provides a sense of community as people begin to rhythmically synchronise. In the session Violets-Gibson (2004) called upon her most valuable prop, the ball. The ball is used as a physical linking prop, linking members of the circle with each other as they interact with the ball. The way in which the ball is interacted with guides the therapist's verbal articulation of the non-verbal process.

> "I verbalise every body part and person's name, to whom they are throwing and who is next to whom, etc. I also highlight displays of feeling, which might show anger, interpersonal rivalry or conflict, bewilderment or caring exchanges, and sexual jokes" (Violets-Gibson, 2004, p.21)

In verbalising the person's name and their response to the ball activity Violets-Gibson gives voice to both the emotional and physical responses of the person. The ball acts as what psychodynamic psychotherapist Winnicott (1965) called the transitional object. Other techniques employed by Violets-Gibson's (2004) included mirroring movements and playing music such as rhythmical songs.

Heather Hill's (Table 8) research looked at the experiential meaning of dance therapy for clients with dementia.

Table 8 – Research by Hill (2006)

Hill (2006) adopted a phenomenological approach in her study. This involved the use of video-taping four individual dance therapy sessions and collecting verbal responses from her client, a woman with moderate dementia:

- A two-part analysis was used; the first involved making a detailed observation, using Laban Movement Analysis, of client's movement patterns and the second analysis of the client's verbal responses.
- Hill (2006, p.168) noticed that some moments in the dance therapy session were more significant than others. Moreover, there was increased complexity in the quality of the client's movements and interactions.
- Hill's (2006, p.170) findings suggested that her client moved from an inability to recognise herself on the video to a position of "recognising herself and re-integrating the positive qualities that she saw; for example the client commented, "I'm glad I'm strong."

Hill's (2006) client illustrates again how the art form is used to structure or connect the person. Hill (2006), like Shustik and Thompson (2001), believes that dance therapy and person-centred care share a similar humanistic approach to that of Kitwood (1997) and his models of positive person work and personhood. However, Hill (2006) observes that person-centred dementia care has yet to integrate fully the idea of embodiment; how the person's body relates to his/her identity (Jones, 2005). Hill (2006, p.174) thinks that dance therapists have an important role to play in person-centred approach; namely to develop "embodied" ways of working.

Table ten offers an overview of the shared and distinct key concept emerging from the post-1990 literature.

Table 10 – Overview of Key Concepts in Post-1990 Literature

Discipline	Shared Concepts	Distinct Concepts
AT	Goals of therapy • Autonomous functioning • Sense of Control • Well-Being • Engage sensory world • "Holding" memory"/sequencing • Symbolic nature of work • Use of objects as stimulus Theoretical influences Person-centred • Personhood Psychodynamic • The relationship • Transference dynamic • Group dynamic	Assessment US • Diagnostic potential of image making • Assessment potential Mari Card Test + Mandala
MT	Goals of therapy • Mirroring/modelling • Sequencing Theoretical influences • Person-centred	Goals of therapy • Behaviour management (US) • Therapeutic song Theoretical influences Neurobiological/ Physiological • Limbic system • Kairos/time structure Art form • Improvisation • Pre-composed
DMT	Goals of therapy • Cognitive reorganising • Mirroring movement • Reminiscence Theoretical influences • Person-centred • Psychodynamic	Theoretical influences Neuroscience • Demasio Art Form • Laban • play • song Psychodynamic • Attachment
DT	Goals of therapy • Symbolic nature of work • Well-Being • Sequencing • Mirroring Theoretical Influences • Person-centred • Psychodynamic Winnicott	Theoretical influences Art form • Theatre model • Community theatre model • Reminiscence theatre • Dramatic play • Therapeutic story • Ritual Psychodynamic • Developmental approach

Summary of themes emerging from the literature.

Many of the general themes relating to arts therapy work with older people identified in the pre-1990 literature were revisited in the post-1990 writing and developed in relation to the older person who has dementia. A selection of the overarching themes emerging from the literature is brought together and critiqued in the following section.

Genre of the literature

The literature reviewed so far has illustrated how individual arts therapists work with their clients. The published accounts offer an interesting if somewhat fragmented perspective of the field because so few of the writers have written more than one paper about their work. The review highlights the paucity of good empirical UK research; apart from Waller et al's (2006) longitudinal study and Hill's (2006) phenomenological study the quasi control methods employed by Odell-Miller (1995) and Wilkinson et al. (1998) tell us very little about the field. Writing from the US is dominated by empirical research primarily in the form of RCTs (Lou, 2000; Gerdner, 1992) that focus on music as a tool for behaviour management. The contrast between the UK and US writing creates a tension for UK arts therapists in terms of locating their own practice knowledge. There is an urgent need to map the field.

Move from activity to therapy

In the pre-1990 arts therapies and older people literature focuses more on the activity rather than the therapeutic aspect of the work. For example, in the AT literature a range of activity tools and directive techniques are discussed (Dewdney, 1973). Similarly, in MT there is a rebuff by Towse (1995) of Allen's (1979) early writing because it points to a style of work that is remedial in focus. During the 1970s and 1980s arts therapists writing about the field were developing their ideas within the parameters of the dominant biomedical model. This point is illustrated by the early focus in AT on developing an assessment tool (Wald, 1983, 1986; Simon, 1985). In UK terms Simon's (1985) writing on assessment seems premature

in light of the embryonic state of AT with the elderly in the UK. Perhaps this explains why the model was not adopted into UK practice.

As UK/European writing emerged (Byers, 1998) the focus changed from art as an activity (driven by behavioural concepts underpinning US practice) to art as a form of therapy. This new approach was underpinned by psychotherapeutic and artistic approaches. In theoretical terms there seems to be a distinction between the art therapists and the other arts therapists in terms of their theoretical orientation. The AT literature focuses on psychodynamic concepts such as transference (Wilks and Byers, 1992; Tyler, 2002; Falk, 2002) whereas MT, DT and DMT writing is underpinned by artistic concepts such as Aldridge's (2000, p.11) concept of "performed identity", Lev-Aladgem's (2000, p.316) discussion of "unofficial ritual" and Arakawa-Davies's (1997) "kinaesthetic awareness." Does this distinction really exist in practice? This study intends to find out.

Goals of arts therapy work

Maintaining identity/independence

Tyler's (2002) comment about the older person being a 'persona non grata' hints at the potential struggle the person has to maintain his/her identity in a society preoccupied with youth. The ability for the older person with dementia to maintain his/her sense of self is further eroded in light of the biomedical model's focus on 'repairing' and 'curing' the person. However, US AT writers Dewdney (1973), Weber (1981) and Wald (1983) recognised, before the emergence of the psychosocial model, that engaging in AT could potentially strengthen the person's sense of self. The literature reviewed in this chapter has suggested that a key aspect of arts therapy work with this client group is maintaining the remaining strengths of the person rather than focusing on his/her deficits. This view is shared across the disciplines (Casson, 1994; Aldridge, 2000; Violets-Gibson, 2000; Waller, 2002). Wald (1989, p.215) reminds us that the arts therapy intervention is not "curative" but "supportive". Interestingly, Wald (1989, p.215) is the only writer to define the work as "supportive" and this made me wonder about the assumptions that other arts therapists made about the level of psychotherapeutic intervention they offered. I

think it is safe to say that none would consider the work to be curative but do all arts therapists assume they are working at a supportive level? It will be interesting to learn the views of the arts therapists interviewed in this study.

A theme closely linked to identity was that of independence. The person's sense of self is maintained in the arts therapy session because he/she is encouraged to engage independently in the art form. In critiquing Harlan's (1990, p.101) notion of "autonomous functioning" I cannot help thinking that her sessions lacked 'space' for her clients to engage in the art form independently. Harlan (1990) argues that a structured activity provides a secure base from which the person can then feel safe to explore independently. It would seem that her approach overemphasises the use of drawing techniques to create this secure base. It could be argued that Byers's (1995) use of the stimulus object rather than Harlan's (1990) drawing techniques offer more potential for the client to maintain his/her independence. However, the use of stimulus objects in AT is controversial due to the psychodynamic nature of discipline. The literature indicates a different stance being taken by DMT and DT therapists with their sessions very focused around using stimulus objects and both disciplines engaging in more structured activities (Bateson, 1998; Violets-Gibson, 2004, Jennings, 2006).

Communication/expression

The literature points to the arts therapies as potential 'alternative' forms of communication and expression (Waller, 2002). The triadic relationship of client, therapist/group and image is different to the traditional dyadic therapist client relationship (Wilks and Byers, 1992). Placing the art form at the heart of the relationship affords the client the opportunity to communicate on many different levels (e.g. metaphorical, symbolic, sensory and kinaesthetic). One interesting disciplinary distinction, in terms of the different types of communication, was the dramatherapists' focus on play (Knocker, 2001; Lev-Aladgem, 2001). Adult play is not discussed in the AT, MT and DMT literature but here we are provided with a concept for distinguishing between child and adult play. Lev–Aladgem's (2001) view of play as a lifelong experience rather than a stage of development helps to broaden our perception of play.

The dramatherapists sit slightly apart from the other arts therapists because the art form engages the client both verbally and non-verbally in the session. The literature points to AT, MT and DMT as primarily non-verbal forms of communication. Descriptions of DT practice centre on the use of the dramatic story (Batson, 1998; Harrow, 2005) something that involves verbal interaction. The reliance of dramatherapists on the verbal skills of their clients raises a question for me about how they work with clients in the later stages of dementia, when verbal communication has deteriorated.

Structuring/remembering

The art form has the potential to structure the person (Jennings, 2006, Falk, 2002, Brotons, 2000, Sandel and Scott-Hollander, 1995). How? Writers suggest that the rhythmcal structure inherent in the person's movement patterns, in the therapeutic song, the sequential nature of the story and image act as a form of structuring. This feature of the work seems to be intuitively rather than empirically understood by the writers in this literature review. For example, how can the muddled exterior space that Falk (2002) describes become a more controlled interior space when the person engages only weekly in an arts therapy session? Sandel and Scott-Hollander (1995, p.136) point to the "cognitive reorganisation" that can happen when the person engages in the art form. The writers contend that the person's memories (reminiscence) are evoked when he/she engages in the art form. Could this idea potentially explain how the person finds some structuring through the art form? This issue is still very unclear and requires further consideration.

Reminiscence is a key feature of this work and one that is mentioned by writers from all four disciplines (Langley, 1987; Tomaino, 1993; Shore, 1997; Coaten, 2002). Helping the person to keep his/her memories alive is one way that the person's sense of self is maintained. The literature suggests that the art form offers the person an access route to memories that otherwise are difficult to retrieve. Again this is a grey area because the writing in this review relies on the subjective experiences of the writers rather than any hard data. One exception is Tomaino's (1993) research on connections between the auditory nerve and the limbic structures.

Role of the arts therapist

The literature review provides glimpses rather than a comprehensive picture of the role of the arts therapist. In the introduction to this study Waller (2002, p.2) discussed the "skilled" arts therapist. This notion may lead the reader to assume that arts therapists receive specialist training in the field after they have completed their generic education. This issue is unclear from this general scoping of the national and international literature but the topic is given further consideration in the next chapter.

In terms of the arts therapist's interaction with his/her clients there is the sense he/she supports his/her client to engage with the art form and to cope with any difficult issues that may surface as a result of this engagement (Donald and Hall, 1999, p.25). Waller (2002) observes that the arts therapist requires a 'flexible' approach, one which enables him/her to adapt sessions, art materials, instruments and props to suit the changing needs of the person (Munk-Madsen, 2001, Moss, 2003, Ridder et al. 2005, Powel, 2006). This is a philosophy that fits easily with the underlying professional assumptions that creativity is spontaneous (Melcer, 1983, Langley, 1983). Waller (2002) hints at the juxtaposed spontaneous yet regressive quality of the work when she speaks of the therapist encouraging and supporting the person to make even *the smallest sound, mark or movement*. It is interesting to consider how arts therapists mediate between these two aspects of the work. The literature review does not discuss the spontaneity of the work in any depth but the regressed nature of the work is explored in terms of how directive or non-directive the therapist is during the sessions. For example, in DMT the therapist guides the client through the movement activity (Arakawa-Davies, 1997). Kamar's (1997) introduction of the dotted image and Byers (1998) use of the stimulus object point to directive input in the AT sessions. Similarly, in MT Simpson (2000) uses pre-composed music in the early sessions with Edward. There is an underlying assumption that confused clients require direction from the therapist. This is a complex issue particularly for AT and MT therapists because the literature points to this challenging their psychodynamic psychotherapeutic and artistic theoretical assumptions. The issue is not the same for DT and DMT therapists because the 'activity' aspect of their art form means that they mediate more between directive and non-directive elements including the use of props. This topic, including an in-

depth discussion of the therapists' theoretical orientations is offered in the next chapter.

Chapter summary

Having identified some of the overarching themes underpinning the arts therapies and older people/dementia literature chapter five narrows the focus of the review to consider the key areas of UK/European practice.

Chapter Five

Key Areas of Practice

Overview

The previous chapter illustrated the diversity of emergent thinking underpinning the arts therapies and dementia field. In order to contextualise the study in the relevant literature I offer a review of the writing pertaining to key areas of predominantly UK/European arts therapies and dementia practice. The *key areas of practice* discussed in this chapter were developed initially from my own *a priori* knowledge of the field and in consultation with the participants.

Professional background of the arts therapists

There was no indication within the arts therapy and dementia literature about the prior training and career of arts therapists working in the dementia field. Arts therapy training in the UK is at postgraduate level. Many arts therapists have prior training in the art form at undergraduate level. Karkou (1998) noted from her study of the wider field that over half of her participants' first degrees were primarily in a related art form. As AT and MT are the largest fields, the writer noted that it was these disciplines rather than DMT and DT that drew on applicants who had a formal arts training. Fifty per cent of all applicants to AT and MT courses had formal arts training while only thirty per cent of those from DT and DMT were trained in the respective art form. The remaining students came from education, social/community work, nursing and related fields (Karkou, 1998). The study did not indicate if the interviewed arts therapists were just trained in these fields or if they were trained and had a career in these fields.

The pathway of arts therapists coming into the actual dementia field was also unclear. I found a few ad hoc references made by arts therapists concerning their reasons for working in this area. Waller (2002) has written of her personal experience of dementia through caring for her partner with Parkinson's disease (PD). On a professional level Waller (2002) also wrote that the art therapist

recruited to take part in her research project began his work at the Towner Club on a voluntary basis where he worked weekly with a group. Dance Movement Therapists Crimmens and Kelly (1994) began their work while on placement. There was no clear indication in the arts therapies and dementia literature about the pattern of employment of the arts therapists. Karkou's (1998) PhD findings indicate that arts therapists are primarily employed in the health, social/community, education and voluntary/private sectors. Arts therapists employed in the health service are more likely to be in established or permanent posts, while those working in community/social services are employed on a more short-term basis, depending on project funding. Findings from her study suggest that full-time employment for arts therapists is limited; instead they appear to undertake predominately part-time or sessional work.

One interesting observation made by the US art therapist Spaniol (1997) was what she described as the 'paradox' facing arts therapists working with older people. As we all live longer there is an increase in older people in society but for art therapists there is a decrease in available jobs as market forces reduce employment opportunities.

> "One in eight Americans is now over sixty-five, and that ratio is expected to increase to one in five by the year 2030. Concurrently, many art therapists are losing jobs or unable to find work due to the effects of privatization, managed care and downsizing" (Spaniol, 1997, p.158).

The UK music therapist Kelleher (2001) made a similar point, saying that despite the availability of state registered music therapists, often settings are too small and/or do not have the resources to hire professional qualified music therapists. She observes that a full-time therapist is often too costly, so what tends to happen is, the therapist is paid to work sessionally for a few hours a week, or is required to work in diverse ways. For example, Towse (1995) has written of running one therapy and one recreational group. Clearly, the employment status of the arts therapists' work can have an impact on the field in terms of its development. Arts therapists working in non-permanent posts often have to leave the field and then re-enter it as work becomes available. This study intends to discover what the job situation is like for arts therapists working with people who have dementia.

Spaniol (1997) made an interesting observation.

> "Opportunities to work with older adults will inevitably continue to grow relative to other populations, yet many art therapists (as well as other mental health professionals) are reluctant to work with elders" (Spaniol, 1997, p.158).

Despite the current state of arts therapy jobs as outlined by Karkou (1998), arts therapists working with older people are in a rapidly expanding field, one which may provide more jobs. However, according to Spaniol (1997) it is the art(s) therapists themselves that are reticent about the work. In an attempt to undercover why this paradox exists, Spaniol (1997) described how she brought together a group of fourteen AT clinical directors from across the state of Massachusetts. Spaniol (1997) noted that many of the responses from the directors were predictable, for example, they talked about prejudices in society against the older person. The writer comments that only one director took the blame away from society, health professionals and the older person. The respondent said that, "arts therapists avoid working with elders because they feel *culturally incompetent"* (Spaniol, 1997, p.158). Often therapists lack an understanding of the life cycle, in particular how to work with people who are older than themselves and the issues that come with working with the aged.

The client and the dementia care setting

Chapter one illustrated the different types of care that are available to the person as the disease progresses. Arts therapists will potentially meet their clients in either the hospital, the community day or residential care setting. The literature in chapter three outlined the psychological and emotional issues that impact upon the person as a result of his/her diagnosis of dementia and subsequent attendance at day care and eventual move to residential care.

The UK arts therapies and dementia literature offers no detailed discussion of which of the three types of settings the arts therapists predominately work in with their clients. Are most arts therapist based in community residential, hospital or in community day care settings? The type of setting that the arts therapists work in potentially has an impact on the work they do, for example if arts therapists are working with someone who has just been diagnosed with dementia is the work

different to working with someone who has more advanced dementia? Another consideration in relation to the type of setting that arts therapists work in are the issues that they face when working in these care settings. Powell (2006, p.8) outlined the issues facing the clients. She observed that the daily living of the older person was "dominated by functional care", there existed unmet social and occupational needs in terms of an interactive activity and that there was a lack of "space and support" to help the person deal with the many changes that were happening. Waller (2002), Coaten (2001) and Aldridge and Brant (1991. p.1) outline the issues facing the medical/care staff but do not discuss the issues pertaining to how they negotiate their own role in the setting. The only comment I found was from Aldridge and Brant (1991) who suggested that it is possible for arts therapists to work with medical staff as long as they negotiate a common language. Do the arts therapists interviewed in this study share a common language with their medical/care staff colleagues?

Therapy space

In terms of therapy space, the psychodynamic concept of the "holding environment" (Winnicott, 1965, p. 45) is an important concept for some arts therapists. The mother (therapist) creates a holding environment for the child (client), an environment in which the child feels safe. Tyler (2002, p.82) observes that "a sense of continuity, privacy, familiarity and trust can be fostered by providing a constant time and place, free of interruptions and distractions from outside." Jones (2005) notes that private, creative spaces are important for art therapists but not necessarily for the other arts therapists who may prefer to practice in more open spaces. Powell (2006) suggests that the arts therapist and the medical/care staff need to be flexible in terms of how the space is used and how confidentiality is maintained. Powell (2006) and Harrow (2005) ran their sessions in communal spaces within the setting where they worked. The dramatherapist Harrow (2005, p. 19) used to create an "area of play" where she (sat) still in a "strategic place" (corridor, toilets) and waited for the clients to come to her. She observed that "stillness is a powerful tool in dramatherapy and helps settle fluctuating energy" of her clients and begin to introduce them to the DT process (Harrow, 2005, p.20). The music therapist Moss (2003) had MT sessions with her clients in the later stage

of dementia at the person's bedside. Kamer (1997, p.119) noted that she worked with Steve in a "large room where many activities took place simultaneously."

There can be challenges with regards to finding an appropriate private or communal therapy space in the residential care setting (Powell, 2006), less so in the day centre where there may be more activity type rooms available. Residential settings do not have purpose-built therapy spaces but rather the therapist has often to secure a lounge, kitchen or bedroom in which to work with his/her client(s). Morrin (1988) stated that art therapists need a suitable room with easy access to water tap and wash-hand basin and somewhere for storing art work safely. Rooms require to be set up and cleared away before and after the session (Waller, 2001; Powell, 2006). Coaten (2001, p.388) comments, that the sessions should be undertaken in a "separate room which is warm, light and airy." Violets-Gibson (2004) believes there is a need for a large space with a "porous boundary" so that those in the chair circle have room to move. If the circle is too tightly closed then this may cause conflict as people are confined within the rigidity of the space. Whatever, the nature of the space Ridder and Aldridge (2005) and Waller and Sheppard (2006) acknowledge the importance of it being the same each week so that the person is able to feel safe. It would seem that the arts therapists have different views with regards to the type of therapy space they require. This study intends to elicit a more comprehensive picture of what type of therapy space is used by the arts therapists.

Therapy Work

Referral

There is limited discussion in the UK arts therapy literature about the referral process. Powell (2006) and Crimmens and Kelly (1994) describe going into the setting before the session and speaking with potential clients, inviting them to the session. Coaten (2001, p.388) talks of "preparatory work (being) done with participating staff to ascertain the cognitive and emotional state of the participants." Hospital-based arts therapists such as Odell-Miller (1995) write of specific clients being referred by the care team. Powell (2006) believes that arts therapists must be given time before a session to speak with potential clients and staff. Morrin

(1988) makes the point that potential clients in residential care should have the choice whether or not to participate in therapy. This point is echoed by Crimmens and Kelly (1994, p.14) who talk of “respecting and accepting their choice to come or not.” Nursing assistants/care staff have an active part in the referral process. They play an important part in the referral process in terms of getting clients to come to the session. Powell (2006) writes that care staff helped not just with referral in her setting but also with escorting clients to and from the session. Crimmens and Kelly (1994, p.14) write that they walked clients to the session, finding this an important time for “making valuable contact” with the person.

The reason cited for the referral of a person to arts therapy service was because the care team was finding the person’s behaviour difficult to manage. In the case of “H” referred to MT with Odell-Miller (1995) the reason given was that he was unsettled and aggressive. Vink’s (2000) study of music therapists in the Netherlands suggested that clients were referred “because they had social problems, became agitated, or displayed passive behaviour" (Vink, 2000, p.127). Referrals to Moss’ (2003, p.85) pilot clinical study were referred because they were “experiencing high levels of anxiety.”

Group or individual work

A person may be referred to group or individual arts therapy. The descriptive accounts of practice given in the DMT and DT literature suggest that the person who has dementia is primarily referred to group work (Coaten, 2001; Violets-Gibson, 2002, 2004; Jennings, 2005). Group work is an important feature of both these disciplines. The US writer Levy (2005) observes that in DMT.

> “Most dance therapists who work with older adults do so in a group setting. The group provides a safe and supportive atmosphere that fosters communication and sharing. Significant benefits are also derived from the effects of physical contact especially touch” (p.229).

In personal communication with Jennings (2005) the leading dramatherapist, she said that the aim in DT is always to work with the group, in this way the therapeutic relationship is following our natural tendency to be a member of the social group. In terms of the AT and MT literature, even though therapists in these disciplines reported that they undertook a mix of individual and group work the actual case

study accounts of practice suggested the dominance of group work (Odell-Miller, 1995; Waller, 2002; Falk, 2002). However, there were some examples of individual work; Kamar's (1997) work with Steve and Simpson's (2000) work with Edward.

As table five in the previous chapter illustrated, Vink's (2000) music therapists in the Netherlands had a preference for undertaking group and individual work with clients in the early stages of dementia but just for individual work with clients in the later stages of dementia. As Vink (2000) observed, the issue was often funding related because it was more economically viable for care settings to have the music therapists doing group rather than individual work. Powell (2006) gives an example from her own practice where her manager felt that group work worked well in the unit, while she herself felt that individual work would have been more beneficial for her clients.

In terms of group dynamics the size of the group can be important. Jennings (2006, p.30) advocates "working in small groups rather than in a crowd." The literature suggests that the optimum group number is between five – eight clients (Morrin, 1988; Harlan, 1990; Odell-Miller, 1995; Towse, 1995; Vink, 2000, Jennings, 2006; Coaten, 2001). There may be a lot of pressure from those funding arts therapists to include as many clients as possible in a session (Johnson et al. 1992).

Moss (2003) worked with a combination of what she termed *open* and *closed* groups. Her *open* group sessions would involve the clients gathering in the lounge and doing some singing. In her *closed* group work a small group of clients would work together with the therapist. Lev-Aladgem (2000) writes of the complexity of setting up a group in a day centre when there is a constant flux of clients coming and going. She set up an open group which enabled new people to join the group and gave those leaving it a gentler end to the work. I found that the majority of arts therapy writing did not specify which type of group work was undertaken.

Johnson et al. (1992) in discussing group dynamics point to the fact that homogeneous grouping is not always possible with AD clients. The reason is that clients may wander around the room or become too close to another person in the group and not give that person space to participate. For this reason it can be difficult for the arts therapists to determine group compatibility and stability. Despite

these difficulties the writers do consider that group cohesion is possible if the arts therapist allows for a permeable boundary, one where the client is allowed to leave if he/she is feeling anxious (Johnson et al. 1992, p.274). Moreover, familiarity with biomedical as well as psychological factors such as the type and stage of dementia experienced by the person could help the arts therapist to better understand their clients' responses. Grossman et al (1986) concur, suggesting that arts therapists must carefully assess who goes into the group because putting people together who are at different stages of AD can lead to some people feeling dehumanised as more able clients avoid contact with those less able.

Duration and frequency of sessions

In respect of the frequency of sessions, the arts therapists Odell-Miller (1995, 1997) Harlan (1990), Towse (1995) and Kelleher (2001) point to most arts therapy work being weekly sessions. Ridder and Aldridge (2005) suggest that ideally work should begin at the onset of dementia and the person should receive four to five short sessions a week rather than one longer weekly session. The US art therapist Harlan (1990) advised that sessions run two to three times a week.

Not much was written about the duration of the sessions. Odell-Miller (1995) made reference to sessions lasting anything from thirty minutes to one hour while Kelleher's (2001) MT group ran for one hour and thirty minutes.

Assessment

Little is written within the UK literature with regards to how arts therapists assess their clients. Aldridge (1998, p.4) has written about the potential for music played within a MT context to be used as a "sensitive complementary tool for assessment. In talking about assessment, Aldridge (1998) views music as an aid, alongside the standard MMSE (Mini-Mental State Exam), to help diagnose dementia. Aldridge (1998, p.4) advocates that the missing elements in the MMSE such as minor language difficulties or "fluency" and "intentionality" may be understood through the playing of improvised music. One of the key ideas espoused by Aldridge (1998) is that the person with dementia experiences a loss of rhythmical structure and it is this structure that helps the person predict or discern what is happening to them

(therefore maybe a valuable assessment tool). Raijmaekers (2007) also felt that MT could be used in diagnosis. He created an orientated observation programme looking at the cognitive, emotional and interactive functions of the elderly for this purpose. Raijmaekers (2007) and Aldridge's (1989b) discussion of the diagnostic potential of MT is reminiscent of Wald's (1989) discussion on the assessment potential of the image. These ideas have not been discussed in the UK literature. One reason for this could be related to the paucity of UK writing and that such specific aspects of practice have not yet been considered.

This point is illustrated by the fact that I only found arts therapists who discussed assessment. Munk-Madsen (2001) a Danish music therapist developed a six-part descriptive assessment model in order to structure her observations of her clients with dementia. The following headings were devised:

1. Music activities
2. Motor activities and quality
3. Emotional level
4. Cognition and mental activity
5. Attention and contact
6. The clients' comments/reactions to the music therapy session.

Under each of the six headings Munk-Madsen (2001) suggested that the music therapist record his/her observations. In the UK literature Towse's (1995) discussed her less formal assessment procedures. Similarly, these involved recording her observations and reflections post session in process notes. There is no indication from the AT, DT and DMT literature about the assessment procedures that are employed by these arts therapists.

Theoreticians and theories

The previous chapter illustrated that there was generally a lack of theoretical discussion in terms of named theoreticians and approaches. Sherrat et al. (2004) suggested that the reason for this, in MT, was that the focus of writing and research has been on efficacy rather than theoretical discussion. This appears to be true for most of the arts therapy literature except for AT where the picture is slightly different. Most AT writers frame their case study descriptions within the context of psychodynamic principles (Wilks and Byers, 1992; Falk, 2002; Tyler, 2002; Waller, 2002). According to Waller (2000) there is a historical alignment between AT and psychoanalytic/psychodynamic thinking.

In view of the lack of theoretical debate within the dementia field, I decided to use Karkou and Sanderson's (2006, p.75) mainstream model of arts therapy theoretical influences to frame the theoretical assumptions made by writers in the arts therapy and dementia literature. The model is framed around six key approaches and is ranked in order of the most influential approach.

1. "Humanistic
2. Eclectic/Integrative
3. Psychoanalytic/psychodynamic
4. Developmental (omitted)
5. Artistic/creative
6. Active/directive."

One amendment to Karkou and Sanderson's (2006) model is that the fourth most influential approach, *developmental,* is omitted. Apart from Johnson's (1992) use of the developmental model in DT no other writer discusses this approach in relation to people who have dementia

"Humanistic"

Karkou and Sanderson (2006) identified the *humanistic* approach as being at the core of arts therapies practice. The approach is framed by a collection of

psychotherapies, therapies that focus on the personal growth or development of the person, in whatever capacity that might be. One of the primary humanistic therapies is the *person-centred* approach espoused by Carl Rogers (1951). Rogers' approach locates the therapist in the role of listener and reflector, someone who mirrors back to the client what he/she has revealed during therapy. The therapist takes a non-directive approach, taking her lead from the client rather than making a direct interpretation of the client's verbal and non-verbal responses. The approach is centred round the core conditions of congruence, empathy and accepting. The person-centred approach underpins the *new culture of dementia care* envisioned by Kitwood and colleagues (Kitwood, 1988, 1989, 1990, 1993, 1997; Kitwood and Bredin, 1992; Kitwood and Benson, 1995).

The findings from Vink's (2000) study of music therapists in the Netherlands found that "psychoanalytic music therapy was the least popular while humanistic was the most popular" theoretical influence. Ridder and Aldridge (2005) suggested that person-centred ways such as holding, validating and empathy share much in common with MT ways of working. Moss (2003) talks of her work being influenced by the person-centred approach, by which she means employing a variety of person-centred music techniques such as improvisation and receptive music depending on the needs of her clients. In DMT Heather Hill (2001), Shustik and Thompson (2001) and in AT Queen-Daugherty (2001) see a close alignment between the principles of Personhood and the aims of AT.

One of the person-centred principles evident in the UK literature is *flexibility*. Waller (2002, p.2) in her definition of the arts therapies (in the introduction) talks of "The material and methods of the arts therapists (being) flexible." There is an assumption within arts therapy practice that the arts therapist must adapt his/her style to suit the needs of the client (Tomanio, 2000, Munk-Madsen, 2001). In this way the choices the person makes in the session are validated. Batson (1998, pp.19-20) illustrates this point.

> "I do not seek to jolly people along into activities that do not interest them. Rather, I endeavour to respect my clients as individuals and try to empower them so that they can live as fully as possible. I value them for who they are now as well as wishing to validate their life's experience."

Validation for Wald (1989) means the art therapist recognising when the client might need something, for example a paintbrush to be placed in his/her hand when coordination problems become apparent. Alternatively, the art therapist recognises the need to offer verbal prompts to encourage the person when he/she becomes stuck. Johnson et al. (1992) talk of the importance of enabling the client to create at his/her own pace. Lev-Aladgem (2000) notes that for effective communication to take place there needs to be a match of tempo; this may mean that the arts therapist slows down his/her tempo when working with older clients.

In terms of person-centred principles Waller (2002), Simpson (2002) and Lev-Aladgem (2000) discuss the importance of working in the *here and now* or present time with the client. Simpson (2003) and Lev-Aladgem (2000) acknowledge the influence of Mihaly Csikszentmihalyi's (1990, p.88) humanistic concept of *autotelic experience*. Lev-Aladgem (2000) states that this context is about responding immediately to what the person brings, using it as a present time stimulus for the work. She uses whatever the person brings to the session in terms of mood or feeling as stimuli for her drama input.

Odell-Miller (1995, 1997) suggests that MT promotes *personal growth* because the person becomes part of a meaningful relationship (Odell-Miller, 1997, p.87). Waller (2002) observed that implicit in the act of creating is change or growth, the emergence of something new. Commenting on the qualities required by an arts therapist working with older people with dementia, Johnson et al. (1992) and Wadeson (2000) discuss the importance of the *sensitive* and *empathetic* clinician. Johnson et al. (1992) suggest that it is the arts therapist's ability to empathise that is the *glue* that holds the session together. This notion has been widely discussed in the psychotherapeutic and dementia literature.

"Eclectic/Integrative"

"Eclectic/integrative trends advocate the selection of ideas and methods from a number of different schools of thought within one approach" (Karkou and Sanderson, 2006, p.95). In the literature relating to the dementia field there was evidence of an eclectic/integrative position being adopted by the arts therapists but this was generally not widely discussed. One reason for this might be the

"ambiguous position" (Karkou and Sanderson, 2006, p.95) that arts therapists adopt in terms of calling themselves eclectic/integrative clinicians due to criticism of such a position (Karkou and Sanderson, 2006). I did, however, find some references to eclectic practice in the arts therapy and dementia literature.

Vink's (2000) findings suggest that the music therapists found it difficult to describe the theoretical principles underpinning their work because they mostly work intuitively and are eclectic in their practice. However, Simpson (2000, 2003) writes that his practice was informed by the person-centred principles of Csikzentmihalyi (1990) Rogers (1953) and Kitwood (1997) and also by concepts from developmental psychology such as Trevarthen (1980) and Stern's (1985) ideas on mother-infant communication and by Pavlicevic's (1992) MT model on *dynamic form*.

Coaten (2001, p.20), in DMT, discussed adopting a "person-focused approach" that integrated theories from "the arts therapies, experiential learning, group work and leadership skills and community arts." Although, like many writers, he does not detail the particular theoreticians or theoretical principles that influence his approach. This is a feature of much of the writing and something that this study hopes to clarify.

"Psychoanalytic/Psychodynamic"

Karkou and Sanderson (2006) identify the psychoanalytical/psychodynamic as the third most important therapeutic trend amongst all the arts therapies in the UK. However, when looking at individual influences within each of the disciplines, the psychoanalytic/psychodynamic is the primary psychological influence discussed in the AT literature, less so in the other arts therapy literature. The psychodynamic model as was indicated in chapter two is centred on the person's unconscious behavioural drives and motivations and how these impact upon relational interactions. These are explored in therapy in terms of the transference and counter-transference. The psychodynamically orientated arts therapist views the image, story, piece of music or movement as a triadic or *third* element within the usual dyadic client therapist relationship. In this way the image, story, piece of

music or movement acts as a container, bringing unconscious feelings into consciousness (Morrin, 1988; Waller, 1991; Wilks and Byers, 1992; Smith, 2004).

In terms of the dementia literature Simon (1985), Wilks and Byers (1992) and Jennings (2006) comment on the *relationship*; they suggest that therapy offers the person a form of constancy, engagement and support that is often lacking in the person's life. The role of the arts therapist is viewed in terms of his/her ability to support or keep the emotional life of the person alive despite the disintegration of the intellectual life (Wald, 1983; Simon, 1985; Harlan, 1990; Wilks and Byers, 1992). Jennings (2006) observes that the relationship needs to be a balance between routine and surprises, that the person has a structured interaction but one that offers up a new experience. Tyler (2002) and Wilks and Byers (1992) observe that psychodynamic orientated AT may afford the person the opportunity to resolve existing conflicts, that the non-verbal image acts as a container for the symbolic feelings that are often too painful to be processed verbally. Melcer (1983) attributes this to the regressive quality of creativity, the creative act affords the person the opportunity to return to an earlier state, one which Melcer (1983, p.12) suggests "compliments the regression inherent in dying." Melcer (1983) believes that the combined creative and regressive elements create a transitional space in which end of life issues can be processed.

In defining the art therapists approach Waller and Sheppard (2006, p.10) in their *Guidelines for Art Therapists Working with Older People with Dementia* suggest that:

> "Many art therapists will have been trained in a broadly psychodynamic model, which implies minimum intervention in the client's art making process. In our experience it is possible to use a psychodynamic approach to the benefit of the clients, but it needs to be modified."

Waller and Sheppard (2006) do not state how the approach should be modified but Morrin (1998, p.247) observes that:

> "It is the task of the AT to create conditions shaped to meet the needs of a specific individual or group. In many instances it may not be constructive to bring unconscious material too close to the surface … such interference may trigger regression, which cannot always be handled usefully. An

> insightful art therapist who is empathetic can convey without words the feeling that the unconscious efforts of the client are understood and accepted, but without bringing more of the materials to the consciousness than can be tolerated."

Morrin (1988, p.247) suggests that a client joining AT should "find an atmosphere of playful warmth and encouragement, with emphasis on self-determination." Wadeson (2000) speaks of an approach that is more subtle and less direct. Wald (1989) observes that the therapeutic relationship is supportive not curative. Odell-Miller (1995, p.339) concurs with Wald (1989) and Ingrebretsen (1987) that psychodynamic work with this population should not necessarily follow "the classical technique" but rather be tailored to the person's needs, for example, a more supportive therapy type intervention where issues of transference and counter-transference are not fully explored and "an overall group dynamic" is not possible according to Wilks and Byers (1999, p.99), although this last point is disputed by Johnson et al. (1992) who believe that group cohesion is possible with this population:

> "Therapy in these settings is not the sort of psychotherapy arts therapists provide in psychiatric facilities. The ways that the arts therapists provide treatment are likely to be more subtle and less direct than in psychotherapy. The work may or may not be insight orientated depending on the interests and functional level of the clients. Treatment goals are often centred on improvement in current quality of life, which may include socialization to counter isolation, self-expression, adjustment to current life conditions, and increased self-esteem" (Johnson et al. 1992, p.368).

Although insight-orientated work may not always be relevant in the session, Johnson et al. (1992) believe that a psychodynamically orientated arts therapist must be aware of his/her own responses to what has taken place. They suggest that "when the therapist recognises her own vulnerability she assumes a more empathetic stance with regards to the client" (Johnson et al. 1992, p.276).

In writing about the theoreticians, Saul (1988) and Shore (1997) discuss the influence of Erikson's work on the Life Cycle and Jung's (1978) concept of individuation. Saul (2000) and Wadeson (2000) comment on the influence of Butler's (1963, 1974) reminiscence work on AT. The writers believed that such work could help the arts therapists frame the way events from the past are experienced by their clients. As discussed in chapter four, Wilks and Byers (1992)

and Tyler (2002) suggested that an aim of AT was to help clients try to resolve past conflicts in order to let them go. Kubler-Ross's (1997) text *on death and dying* was mentioned by Wilks and Byers (1992) as they felt that the stages of death and dying identified were useful for arts therapists to consider.

The music therapists Darnley-Smith (2002, 2004), Odell-Miller (1995, 1997) and Towse (1995) were informed by psychoanalytical/psychodynamic theories. Mary Priestly (1975) a pioneer of psychoanalytical MT brought to the field an understanding of the interactive relationship based on psychoanalytical theory and practice. Odell-Miller (1995, p.85) observes that the interactive relationship between client and therapist "is borne out by paying attention to the psychoanalytical theory and practice." Odell-Miller (1995) employs psychodynamic principles in practice to encourage her clients to give voice to their feelings, once a trusting relationship has been established. In the DT and dementia literature I found limited published work relating to psychodynamic influences. Apart from Langley's (1983) statement that psychodynamic theories influence DT practice there has been no discussion of the ideas advanced by the US writer Johnson's (1985,1986) development model was influenced by object relations theory as espoused by Klein (1975). In DMT one writer, Marion Violets-Gibson (2004), mentioned that she was influenced by psychodynamic principles.

"Artistic/Creative"

In terms of the artistic/creative approach this is related to the group of arts therapists who view themselves foremost as artists (Gilroy, 1989). Dramatherapists position themselves at the centre of the artistic/creative debate.

> "Dramatherapy means therapy that is in drama itself – all drama – and not merely the use of some aspects of drama as therapeutic tools" (Andersen-Warren and Grainger, 2000, p.15)

Jones's (2005) observes that DT practices are shared worldwide, this suggests a different focus to that of, say, AT practices. AT practice is less rooted in the artistic tradition and more in psychoanalytic/psychodynamic. The art form is at the heart of DT (Andersen-Warren and Grainger, 2000). In the previous chapter I noted that

Lev-Aladgem (2000) had discussed play and the unofficial ritual while Knocker (2001) discussed play and metaphor. Casson (1994) and Crimmens (1998) and Gersie (1987) discussed the use of the therapeutic story. Casson (1994) also wrote about play and metaphor in DT. These are all important elements within mainstream DT literature as Jones (2005) illustrates in the following statement:

> "Areas within the realm of drama include improvisation, play based processes, role play, mask, puppetry, drama games, voice work and script". Some forms such as role-play and those rooted in psychodrama emphasise direct playing of reality. Others using story, myth, image and movement stress the creation of metaphor or symbols to enable the client to explore material" (Jones, 2005, p.42).

In terms of artistic theories pertaining specifically to older people who have dementia, Langley's (1983) discussion on Reminiscence Theatre seems to be the only direct reference, but this approach is not widely discussed. More integrated artistic approaches are discussed by Jennings (2005) who writes about creative ageing and the benefits of artistic activities framed around techniques from the more mainstream social theatre model. Similarly, Lev-Aladgem (2000) writes of adapting the community theatre model that she was trained in. The model is based on long-term closed group work within a particular community. Aspects of a person's life are introduced into the sessions and used to frame the dramatic exercises, these are then recorded and a play written and performed. The author realised that older people with memory problems would not be able to recall huge amounts of personal story but felt that the frame of playing in the form of simple dramatic structures could meet their existing abilities. She suggested that Stanislavski's work on working with the "given circumstances" lends itself to this process (Lev-Aladgem, 2000, p.6). This study needs to uncover if specific DT and dementia theories are used or if dramatherapists are adapting existing models. This same point is relevant to all the arts therapies.

Chapter four illustrated that some discussion was taking place in the MT literature regarding live improvised, pre-composed (or structured song) and receptive music (clients listening to generally pre-composed music played by the therapist or on a CD player) techniques. Odell-Miller (1995, 1997) states that MT in the UK centres around two key elements, those of "live music" and of "interaction with the therapist" (Odell-Miller, 1995, p.55). She comments that MT roots stem from live or active

music being played by skilled musicians to psychiatric patients. In MT the term for unplanned live/active music (Darnley-Smith, 2002) is improvised. This means that the client and therapist meet each other in the music through experimenting or improvising with each other's sounds and responses, thereby creating a musical dialogue. As already mentioned, this is a key part of UK MT practice (Odell-Miller,1995; Towse,1995; Darnley-Smith, 2002).

While improvisation is clearly a key element within MT, there is an ongoing debate in the MT and dementia literature about the use of pre-composed/structured song and receptive music. Odell-Miller (1995) and Towse (1995) comment that the use of pre-composed and receptive music in the UK is not widespread because it is mainly a feature of US MT practice. In the US, receptive, or more precisely individualised music (Gerdner, 1992) is common. However, Towse (1995), unlike Odell-Miller (1995), believes that receptive music should be a feature of UK MT work with the elderly because it offers the opportunity to target the person's strengths rather than their weaknesses. She observes that someone with deteriorating skills will not feel empowered by improvising a piece of music that highlights his/her impairments, but might prefer to sit and listen to music which might awaken memories and moments of special meaning. Towse (1995, p.329) notes that:

> "Conventional diatonic or polyphonic Western music can be beautiful and can provide the listener with a profoundly moving experience. However enthusiastic one may be about atonal music, it is difficult to imagine a free improvisation touching the soul with the sublimity of some composed music."

Towse (1995, p.338) makes the point that receptive music is not passive "entertainment" music but rather engages the person in "free-floating attention", a particular combination of concentration and letting the mind wander which then gives material for discussion." Munk-Madsen (2001, p.206) employs "music material from the various music genres." "Music from the clients' lifetime can help to retain or regain a fading sense of identity and can be a means to create a connection between past and present" (Munk-Madsen, 2001, p.207). Odell-Miller (1995), critical of the overuse of pre-composed music, observed that while pre-composed music is used within improvisation for example, therapists and clients are influenced by the sounds around them and as such these may be incorporated into an improvisation.

For Odell-Miller (1995, p.86) the distinction lies in whether “the therapist adapts the music because of the therapeutic process, or expects music to be adapted by the patient involved in the process.” She believes that; “music cannot be predetermined or prescribed just as changes in the relationship cannot” (Odell-Miller,1995, p.86). Moreover, she suggests that MT varies from person to person according to individual needs. Moss (2003) discusses employing an integrative approach, employing improvised, pre-composed and recorded music. Aldridge (2000) and Vink (2000) report that in MT sessions in Germany and the Netherlands both receptive and active elements are used. Ridder and Aldridge (2005) suggest that pre-composed songs or song creation might be part of the active MT, but only as a matter of secondary importance with the function of indicating the start and end of the session. However, taking into account the differing views of Towse (1995) and Odell-Miller (1995), it seems unclear the degree to which both receptive and active music is employed in UK MT with clients who have dementia.

I did not find much discussion in the DMT literature detailing the artistic theories that underpin the profession. Coaten (2001), for example, writes that his integrated “person-focused approach draws on a variety of disciplines including the arts therapies” (Coaten, 2001, p.387). However, he does not expand on what these are. Hill (2006) mentions artistic theories in the form of her use of LMA (Laban Movement Analysis) and the role of embodiment. Overall, the reason for this lack of artistic theory discussion could be linked to the observation made by Sherrat et al. (2004) that articles are being primarily written for other dance movement therapists who already have knowledge of underpinning theories. This study can establish if dance movement therapists working with older people who have dementia draw from artistic traditions that are specific to this client group or are used in mainstream DMT practice.

“Active/Directive”

The *active/directive* trend was acknowledged as the least influential approach by the cross section of UK art therapists interviewed and surveyed by Karkou (1998). In the wider field the approach is generally less favoured in the UK by psychotherapeutically orientated arts therapists, who believe that the more directive the therapist is the less free the client will be to engage in personal exploration of his/her own psychological issues (Byers, 1998). The approach is discussed predominantly in the US literature where it lends itself more to the behavioural model adopted in that country. Interestingly, Karkou and Sanderson (2006) make the point that a degree of direction is always present within UK mainstream arts therapy practice, if we consider, for example, the use of a session structure (beginning, middle and end) and the role of the therapist guiding the client in the use of the props, instruments and art materials.

In UK literature active/directive approaches have not been widely explored, although when they have, they have sparked controversy. As already discussed, Odell-Miller (1995) has stated that she rejects the use of pre-planned, pre-composed music in therapy sessions. This suggests that she tends towards a more ‘improvisatory’ model. On the contrary, Towse (1995) used pre-composed music with her group. Initially she was very directive in that she selected the specific music played in session. However, as time progressed she created a request system in which her group requested week-on-week certain pieces of music. Simpson (2000) has suggested that a more directive approach may be required in MT in order to help orientate the person.

In AT, Smith (2004) and Burns (2007) have acknowledged that a more directive approach in AT might be needed. Burns (2007) observed that the issue is around timing – when or if the person is able to move from a directive to a non-directive state of working, thereby *enabling* rather than *disabling* the person. However, the notion of using directive elements within an AT session is contradicted by Byers (1998) who notes that “art therapy has moved from being directive and activity based, where increased self-esteem is the main objective, to a non-directive approach in which strong counter-transference is recognised as enabling greater empathy” (Byers, 1998, p.111). The issue of whether or not arts therapies employ directive techniques in the sessions is something this study hopes to discover.

The dramatherapists move more easily between directive and non-directive ways of working. This is echoed on the British Association of Dramatherapy (BADth) website in the frequently asked questions section. One question asked; 'do dramatherapists always use an indirect approach?' The reply was:

> 'No, the process and content of the therapy will be based on the needs of the client and negotiated with the client both at the start of therapy and during the therapy. However, the interventions will usually be illuminated within a dramatic framework' (BADth, accessed, 2007, p.6).

In DMT, like DT, there appears to be more of an ease of moving between directive and non-directive elements within a session as structured exercises give way to free-form improvisations. This will be explored further in this study.

Methods

Session structure

Some of the arts therapy literature indicates that sessions are framed by a session structure (Odell-Miller 1995; Reinstein, 2004; Ridder, 2005). In the literature the form that this structure takes and the terminology used to describe the structure varies. Ridder and Aldridge (2005) divided her sessions into four parts: *the constitutional part*; *the regulative part*; *the dialogical part* and *the integrative part*. Crimmens (1997), similarly, adopts a four-stage structure consisting of: (1) *warm up*; (2) *the bridge – the objects; (*this is when everyday objects are introduced to the group for them to explore and respond to 3); *main event – the story*, 4) *the stabiliser,* when the person takes off the prop (de-roles) and returns the object and becomes grounded in the present. Donald and Hall (1999) report that their work fell into four stages: *Initial acclimatising to the group, the emergence of a group identity, the surfacing of difficult or significant issues and resolution.* Odell-Miller (1995) observes that the structure needs to be used flexibly so that sessions are fluid and move with the changing mood and interactions. She adopts the traditional three-part structure of the *introduction*, *central part* and *final part.* I use these here to describe what happens in a session. Further clarity is needed about the type of session structure the arts therapists use when working with people who have dementia.

Introduction

The early part of the arts therapy sessions are about welcoming and acknowledging the client(s) to the session (Odell-Miller, 1995). Hill (2001) discusses the significance of *beginnings* (and endings):

> "They serve to create a separate time and space where things happen which are different from what has happened in the rest of the day. This clear structuring of time is most important for people who are confused and helps focus their attention" (Hill, 2001, p.12).

In AT Wilks and Byers (1992) speak about *beginnings* being about awakening the person's curiosity by encouraging him/her to explore the art materials. Once a preferred art material has been chosen then the person might begin by having a conversation on paper with the art therapist. Each person would take turns to make a mark on the paper to which the other would respond. Morrin (1988) used the pencil doodle as an icebreaker in her sessions.

In MT Towse (1995) first welcomes her group by chatting with them and playing some familiar pieces of music. The group would then speak about the song. Ridder and Aldridge (2005) began sessions with Mrs F with a "hello" song; in the song Mrs F's name was mentioned and she was told throughout the song what was going to happen in the session. Moss (2003) and Falk (2002) acknowledge that the beginning of sessions can be about motivating clients to play the instruments or use the art materials; often clients may initially be reluctant to use the instruments/art materials for fear of seeming childish or being judged, therefore time is spent encouraging clients to engage with the artistic media.

In DT and DMT a key part of the introduction is the warm-up (Batson, 1998). The dramatherapist Batson (1998) gives the example of doing mime work, getting the group to mime waving to each other, engaging the physical as well as the cognitive self. Reinstein (2004, p.19) began his DT session with Mary and Betty by playing the guitar and singing a welcome song. In the song the two clients were encouraged to insert their name "we call her…Mary …we call her…Betty." After singing they did a more physical warm-up exercise of passing the balloon during

which they were encouraged to say their names and describe what they were wearing. Reinstein (2004, p.19) would create a "threshold" in the form of a "crash of a cymbal" to signify the start and end of the story. Lev-Aladgem (2000, p.6) commented that the beginning of her dramatic play sessions began with what she termed "an exterior centred activity." She explained this further:

> "Playing with objects and spaces is a simple dramatic activity on its own, but it is also the preparation stage for the interior, self-centred activity playing roles. Acting out a character demands a certain readiness to openness and mental exposure, which might be threatening at the beginning of an activity for amateur participants and especially the disabled elderly" (Lev-Aladgem, 2004, p.6).

Casson's (1994, p.4) DT sessions with Laura began by them "walking up and down, linking arms with her." She would chat away and he would try and reflect back to her how he perceived she was feeling.

In DMT, Hill (2001, p.13) would do a physical warm-up to get the body active. She also did what she termed a "mental/emotional warm-up."

> "Mental/emotional warm-up is indeed grounded in the physical warm-up process, whereby energy levels are raised, attention and focus are created, and individuals become awakened beyond themselves to the group" (Hill, 2001, p.13).

The warm-up might include "clapping to rhythmical music" and extending this to "clapping different parts of the body" (Hill, 2001, p.13). Coaten (2001) writes that his clients might warm-up by stimulating everyday movements such as hand washing. Verbal prompts are used and age appropriate music is played during the session, during which individual movement patterns are built upon and shared by the group. Coaten (2001, p.388) states that the aim of this part of the session "is to enable clients to maintain their physical condition and mobility through gentle movement to music that is enjoyable, accessible and sociable."

Central part

In terms of the main activity, Wilks and Byers (1992) wrote about “Mrs G” who liked to catalogue the art materials, arranging and rearranging them until they were in the order that she liked. For Odell-Miller (2005) the middle part of the session was about encouraging interaction, awareness and movement using musical instruments and voice building improvisations from the sounds and music expressed by the group (Odell-Miller, 2005). For example, if a group member began humming or beating in a particular way the therapist would interact using the same instrument or a different one in order to become attuned. Odell-Miller (1995) writes that she would begin this improvisation on the piano depending on the mood of the group. She would reflect this back to them. She observes that the type of music structures that were set up varied depending on the needs and mood of each member of the group (Odell-Miller, 1995). Simpson (2000) writes that he spent the earlier part of his session with Edward playing pre-composed music and that it was not until the fourth session that they began to improvise together. This was achieved when Simpson hit the drum three times. Edward responded by vocally repeated the sounds. Simpson then played the sequence on the piano.

> “We moved into an interactive dialogue with Edward adapting both pitch and rhythmic patterns in accordance with what I played” (Simpson, 2000, p.172).

In the middle part of the DT session Reinstein (2004) would offer a series of objects to both Betty and Mary. Included in these objects were “male and female figures, houses, jewellery, boxes and shells” (Reinstein, 2004, p.19). These were used as prompts for a story. As Mary told her story Betty liked to accompany the story with music instruments such as a drum, metallophone or windchime. She commented on the unfolding story. The stories told by Mary ranged in content from one about Sunday lunch, to another about a girl who had run away from her “cruel” mother. In the middle part of Casson’s (1994) session with Laura, Laura was invited into a private room in which Casson (1994) had a series of objects similar to those employed by Reinstein (2004). Laura was interested in a miniature boat and she sat down, took her shoes off and proceeded to try on the boat as if it was a shoe. Casson (1994) took on the role of a shoe attendant and he massaged her feet.

Batson (1998) and Jennings (2006) write in more general terms about types of drama activities that might be used in the middle part of the session. Batson (1998, p.20) writes that he used “mime, story making, role-play, object work, movement and music, games and play.” Jennings (2006) discussed integrating arts and craft work such as clay modelling, poetry and play readings and fairy stories. As mentioned in chapter four, she wrote of performing Lysistrata with a group of Arab, British and Jewish actors in Israel at an Alzheimer’s day centre. At the end of the play one of the women wanted to play Lysistrata. They developed a workshop where the clients could try on the costumes, play the musical instruments and role-play brief dialogues.

In DMT Hill (1992) uses a variety of themes in her sessions. In Coaten’s (2001) sessions the warm up movement patterns are built upon and sensory awareness is engaged through employing different body parts in the movement and through interaction with props. Shustik and Thompson (2001, p.50) note that it is important for the therapist to “wait for permission, whether verbal or kinaesthetic” before reflecting back to the person the movements the person has made. The reason for this is that a person’s emotional response may vary and as such dance movement therapists need to be sensitive to the non-verbal cues that facilitate their clients reflections on the process. An important element in the DMT session is the prop or props. Caplow-Lindner (1982, p.170) observed that, “by responding with movement through something other than their own bodies, inactive people can overcome feelings of lethargy, self-consciousness, or self involvement that might be inhibiting or destructive.” Props used in DMT include the ball (Violets-Gibson, 2004), silk scarves, stretch cloths, different lengths of material, hats, masks and canes (Coaten, 2001). Different props, musical instruments and art materials are used in all the arts therapies sessions. One aspect that emerged in relation to props and materials used by the arts therapists working with older people who have dementia was the use of everyday objects (Byers, 1998; Batson,1998). These are used to stimulate memories and aid symbolic interaction.

Final part

There is no extensive literature on how sessions are ended. I found that MT, DT and DMT sessions often ended with a goodbye song (Reinstein, 2004, Moss, 2003) “goodbye” inserted instead of “hello”. The important aspect was to end the session

in the same way. Ridder and Aldridge (2005, p.94) acknowledge that "a feeling of stability and confidence is maintained if sufficient cues are given with regards to the ending of the session." Daley (1988) acknowledges the difficulty of endings:

> "Although I had reminded them of the ending they did not always hear. Thus part of the group was very distressing and gave rise to feelings about all the unsatisfactory endings that had occurred in their lives" (Daley, 1998, p.32).

Coaten (2001) writes that at the end of his DMT session participants are invited to "re-identify" with their props and discuss any associated memories. The events of the session are "summarised and reflected upon verbally" before the group sing a goodbye song together (Coaten, 2001, p.389).

Evaluation

Very little has been written about how arts therapy sessions are evaluated. Odell-Miller (1995) wrote of doing an ongoing evaluation of the clients' needs through observation and getting to know the person. She also reviewed the session with the nursing staff member who was present and together they planned the procedure for the next session. Coaten (2001) wrote that post session he would undertake a review of the session with the care staff who accompanied him in the session.

In terms of evaluating arts therapists' own practice, Smith (2004) has suggested that supervision is an essential part of the work. In supervision the arts therapists can deal with his/her countertransference reaction to his/her client and explore issues related to the practice.

Chapter summary

- This study intends to provide a comprehensive picture of the *background of* how and why the arts therapists come into the field. The literature reviewed does not give us a sense of their prior training and career before becoming arts therapists and how they come into the arts therapies and dementia field. Were they volunteers (Waller, 2002) or did they come to the field

  through placement? (McDonald and Kelly, 1999). What motivated the arts therapists to work in this area? For example, was their late arrival (post-

1990) in the field related to their feelings of “cultural incompetence” (Spaniol, 1997, p.158). Moreover, what is the work status of the arts therapists when they do begin working in the field? Kelleher (2001) suggests sessionally because full-time employment is too expensive for the setting. Is the same pattern of employment shared by all arts therapists?

- In terms of the arts therapists’ understanding of the psychological and emotional issues that impact on the person with dementia, I wondered if the arts therapists’ perceived loss to be the primary psychological issue for their client? Do they have a different understanding of their clients’ psychological and emotional needs? Moreover, do biomedical factors, such as the person’s stage of dementia impact on the work, for example group and individual practice? Jennings (2005) indicated that DTs (and DMTs) prefer to work with a group while writers from MT and AT state that they undertake a mix of individual and group work. However, the literature from these fields is dominated by descriptive accounts of group rather than individual work.

- In terms of setting, this study intends to find out where the UK arts therapists are working, what type of therapy space they use and how the arts therapists negotiate the challenges of finding an appropriate therapy space and working with colleagues from other professions.

- The literature has highlighted the paucity of referral, assessment and evaluation knowledge. It is unclear how clients are referred to the arts therapy service or what type of referral procedures UK practitioners employ. The music therapist Powell (2006) and Dramatherapists Crimmens and Kelly (1994) talk of arriving at the setting and inviting potential clients there and then to the session. I wondered if this was common practice? Or if dramatherapist Daley (1983) and music therapist Odell-Miller’s (1995) experience of having clients referred by the care team was also common practice? In terms of assessment and evaluation procedures there is no clear picture of what types of formal and/or informal procedures are used.

- The literature, primarily non-UK, gives a sense of the group dynamics, duration and frequency of sessions but is it correct that in the UK group

sessions are for around five to eight clients? Do sessions take place weekly or more frequently as Aldridge and Ridder (1995) and the American art therapist Harlan (1990) have suggested? Moreover, is there a consensus on the duration of the arts therapy session?

- There seems to be no literature pertaining to the process of initial assessment. Munk-Madsen (2001) and Towse (1995) write of their ongoing MT assessment techniques based around in-session participant observation and post-session reflective note writing. An interesting consideration for this study is if these same procedures are shared by all the arts therapists.

- The literature review has evidenced the development of theoretical thinking in the field. The writing suggests that music, dance movement and dramatherapists adopt a more integrative/eclectic approach, interweaving psychotherapeutic, artistic/creative and other theories to varying degrees into their practice, while art therapist have focused more on integrating different psychotherapeutic ideas. The writers in this review are often the first and only ones to write of their particular integrative/eclectic approach (Langley, 1988; Simpson, 2000; Marion-Violets, 2004) so this study intends to learn if the practising arts therapists interviewed adopt a similar theoretical approach or if they in turn have created their own integrative/eclectic theoretical approach. Moreover, the study needs to consider if the debates outlined in the literature review, such as the active versus the receptive MT debate advanced by Odell-Miller (1995) and Towse (1995) is of concern to the practising music therapist. Indeed, if there is, as the music therapist Simpson (2000) and art therapist Burns (2007) have suggested more directive work used with this client group, than for example in mainstream practice.

- The literature suggests that the arts therapists employ eclectic methods in-session, in order to meet the needs of their clients. More clarification is required in order to determine shared and distinct practice between the disciplines.

Chapter Six

Research Methodology

Overview

This chapter draws from nursing, social sciences and psychology literature in order to explore the methodology, methods and issues of trustworthiness underpinning this study. As the numbers of arts therapists undertaking research are still small there has been limited opportunity for in-depth methodological debate within the field. With this in mind, I looked to other disciplines to provide a methodological frame for the study. During my search I came across the lively debates being held in nursing literature regarding the role of the practitioner-researcher. In writing this I am aware of the paradox in selecting literature from nursing, a field that is framed by the biomedical model. However, nursing research has engaged with topics beyond biomedical matters with debates concerning the nature and quality of qualitative research, in particular with regards to how nurse practitioners undertake research in clinical settings. These discussions offered answers to similar issues I was faced with as a practitioner-researcher and provided me with a methodological framework that addressed these issues.

This chapter is divided into three parts. Part one begins by briefly highlighting the debates regarding the nature of qualitative research. The chapter then moves on to consider the ontological, the epistemological and the methodological choices I made during the course of the study. The first section concludes by considering reflexivity. The second part of this chapter focuses on describing the *procedures and methods* employed in the study (interviews and participant observations) and it includes a discussion on the sampling procedures employed in the study and the type of analysis that was undertaken. This section of the study concludes with a consideration of ethical procedures. Part three discusses the issue of trustworthiness and illustrates the steps taken to assure quality in the study.

The nature of qualitative research

Since the emergence of qualitative research in the mid-twentieth century there has been ongoing refinement with regards to definitions of research (Lowenberg, 1993). In its simplest sense research was defined as qualitative or quantitative, inductive or deductive. As ideas from philosophy filtered into the research domain, research was viewed in epistemologically. Three major schools of research were identified; the empiricist/realist school, the interpretive school and the critical/feminist school (Lowenberg, 1993). At present further refinement is taking place; for example, within the interpretive school (constructed of phenomenology, grounded theory and ethnography) there is a move to challenge the divisions that currently separate the three methodologies. Today researchers wish to integrate these methodologies in order to explore the richness of the interpretive paradigm (Lowenberg, 1993). Ezzy (2002) observes that each of the methodologies within the interpretive paradigm has its place and distinctive value, but "that each tradition could benefit significantly from a more open dialogue with other traditions of qualitative research" (Ezzy, 2002, p.22).

As qualitative researchers adapt and integrate methodologies, questions about methodological *slurring* and the situating of these new types of qualitative research come to the fore. Caelli et al. (2003) believe that researchers undertaking such research must be transparent about the choices they make to ensure the credibility of their pluralistic research. The writers offer four ways in which the researcher can establish credibility in the research: 1) through discussion of the theoretical position of the researcher; 2) ensuring that there is unity between methodology and methods; 3) offering strategies to establish rigour; and 4) through detailing the analysis process. These issues are discussed throughout this chapter. The journey begins by considering my ontological, epistemological and methodological positions.

Ontology and epistemology

My life has been shaped by my cultural background, by the values and belief systems that I carry with me. My childhood was spent in rural Scotland living in an intergenerational community. Living in a small community with both younger and

older people has powerfully influenced my life. My early training and career was spent working with children as a teacher and then as a support worker. My later career has been spent as an art therapist working with adults in psychiatric care and then older people who have dementia.

My experience of being a practising art therapist underpins my ontological position. Chenail et al. (1997) observe that there is a distinction between when a practitioner-researcher undertakes a piece of qualitative research in the clinical field and when his/her counterpart, a new researcher to the field, undertakes the same type of study. For the researcher this will probably be his/her first experience of the field, so that the methodological choices he/she makes will most likely reflect his/her desire to discover the unknown. For the practitioner-researcher his/her task centres round "sensemaking" (Chenail et al.1997, p.1). He/she will be engaged in "sensemaking from experience" (to confront a priori knowledge), "sensemaking challenged" (to deconstruct previously known constructs) and "sensemaking remade" to move towards reconstructing new knowledge (Chenail et al. 1997, p.1). All of these influences have shaped my way of being in terms of the assumptions and biases that I bring to this study.

In terms of the ontological assumptions, the American educationalist Patton (1990, p.101) asks does the researcher adopt "the radical absolutely no reality ever" position or "the more milder let's capture and honour different perspectives" of the participants. This study is more aligned with the second statement. I adopt a moderate relativist position in recognition of the fact that I have chosen to research a particular group, a group who were united by a certain shared understanding of arts therapy practice with older people who have dementia. However, key to this research study is the assumption that the perspectives or realities of each person are continually being shaped and re-shaped by the cultural, social and linguistic contexts in which he/she lives. In terms of this study, this means that the contextual and constructed (Thorne et al. 2004) realities of each participant will inform and ultimately re-shape my *a priori* knowledge of the field and create a different understanding of arts therapy practice with older people who have dementia. Lincoln and Guba (1985) and Thorne et al. (2004) concur that "no pre-existing knowledge could possibly encompass the multiple realities that are likely to be

encountered; rather, theory must emerge or be grounded in the data" (Thorne et al. 2004, p.5).

Epistemology is concerned with our way of knowing. In research terms this means the type of knowledge that underpins the research project (Willig, 2001). The naturalistic interpretive paradigm, which informs this study, is concerned with understanding the subjective experiences of the participants as they live them (Lincoln and Guba, 1985). The lives of the participants are a construct of multiple realities that are "complex, contextual, constructed and ultimately subjective" (Thorne et al. 2004. p. 5). The researcher and the participants come together to co-create their understanding of the phenomena being studied. Implicit in this relationship is an understanding that each person's perspective is honoured and valued. In this respect consideration is given to the issue of voice and how each person taking part in the research is represented. This means that the researcher does not take a position of objective distance, situating him/her self apart from the participants but rather engages with the participant in his/her world.

Willig (2001) comments that the methodology and methods of the researcher have to be congruent with his/her epistemological position. This means that ongoing questions have to be asked throughout the research about the kind of knowledge, assumptions and conceptualisation that the researcher is making. For researchers influenced by the naturalistic interpretive paradigm a multi-lens approach is required in terms of the methods employed in the study. Multiple methods help the researcher capture the nuances and distinctions that underpin the participant's experience of the phenomena being studied.

Situating this study

My reason for undertaking this study was a desire to understand how arts therapists worked with older people who have dementia. As no other study, I believe, has looked specifically at this area it was clear from the outset that the primary goal of this research study was to map the field, to construct a descriptive account of the practice of arts therapists working with older people who have dementia.

While constructing this descriptive map of the field, I anticipated that each arts therapist would bring to the study his/her own experiences of working in practice. Some of these experiences might be recognisable to other arts therapists and to me the practitioner-researcher as coming from a shared culture; or shared only by arts therapists coming from the same discipline; or they might be experiences that were unique to that particular arts therapist. All of these experiences, shared or unique, would be shaped by the particular social, cultural and linguistic context of the person's particular situation. My job as practitioner-researcher was to make sense of the complex interplay between shared realities and subjective experiences that informed the participants. Taking this into consideration, I realised that as a practitioner-researcher I could offer some interpretations on what I had discovered.

It was clear from the outset of this study that I would need to consider employing a flexible methodology, one that could accommodate the concepts of mapping and interpreting the clinical phenomenon. Chenail et al. (1997) observe that methodological purity is an issue for the practitioner-researcher. The writers comment that for the new researcher to the field adopting one methodology only, like grounded theory, is appropriate because the researcher is seeking out new knowledge. For the practitioner-researcher the aim is "sensemaking remade" (Chenail et al. 1997, p.2) which is a multi-faceted process and one that requires a pluralistic approach.

In order to capture the complex interplay between theoretical and practice knowledge. I adopted principles from the methodology *Interpretive Description* (Thorne et al. 2004).

Interpretive description

Interpretive description is a non-categorical methodology that emerged in response to a call for an alternative way of generating grounded knowledge relating to clinical practice (Thorne et al. 2004). Two elements underpin the interpretive description study

1. "An actual practice goal
2. An understanding of what we know and don't know on the basis of the existing empirical evidence (from all sources)" (Thorne, 2008, p.35).

The questions generated in the interpretive description study are grounded in clinical practice. The starting point for this study was my own knowledge that there was limited understanding about how arts therapists worked in practice with older people who have dementia. The interpretive description study encourages the practitioner-researcher firstly to construct a description of a clinical phenomenon and secondly to move beyond this initial description, through interpretation, toward developing a comprehensive understanding of the field.

As outlined in the previous section, the initial practice goal of this study was to construct a descriptive account or map of the arts therapies and dementia field. In order to generate this map I had to engage in the process of *mapping.* Mapping is defined here as the *searching for* and *gathering of* accounts of arts therapies practice relating to the professional background of the arts therapists, where and with whom they work, how they work in terms of their therapy work and their reflections on the work. Studies employing interpretive description offer a thematic description of a clinical phenomenon (Thorne, 2008, p.75). The goal for the practitioner-researcher employing interpretive description is to produce "a coherent conceptual description that taps thematic patterns and commonalities believed to characterize the phenomenon that is being studied and also accounts for the inevitable variations within them" (Thorne et al. 2004, p.7). The practitioner-researcher aims to "search out and explore features of a common issue (and to) render an understanding of them that honors their inherent complexity" (Thorne, 2008, p.75). In this study the gathered together accounts of arts therapy practice were analysed and synthesised into a first descriptive map of the field. The map is presented in chapters seven to ten of this thesis.

As discussed previously, the practitioner-researcher approaches clinical research from a different perspective to that of the new to the field researcher. The practitioner-researcher brings *a priori* knowledge of the clinical phenomenon to the research. This knowledge provides valuable scaffolding, in the form of an analytical frame, to the clinical context being studied (Thorne et al. 2004). The analytical frame is a tool for guiding the practitioner-researcher's reflexive and critical appraisal of the research and to help him/her construct new meanings about the phenomenon (Thorne et al. 2004). In this study, the start of the analytic framework came via initial detailed discussion with my director of studies concerning our respective understanding of the field(s). My director of study had knowledge of the

wider theoretical, clinical and educational underpinnings of the arts therapies field. My own knowledge was more localised to AT with older people who have dementia. As the study progressed this initial scaffold was built upon, as alternative ideas and concepts emerged.

Thorne (2008) suggests that techniques such as the analytical frame situate the methodology of interpretive description beyond purely qualitative description and lead the practitioner-researcher to consider what aspects of the descriptive phenomenon maybe interpreted. Thorne (2008, p.35) comments that the aim of the interpretive description study is to, "deconstruct the angel of vision upon which prior knowledge has been erected and to generate new insights that shape new inquiries as well as applications of "evidence" to practice." In the 1980s theorists from the descriptive-interpretive paradigm advocated the importance of the practitioner's knowledge in theory building (Fealy, 1997). They suggested that by employing the practitioner's knowledge practice-based research kept up-to-date with the constantly developing strategies that were happening on 'the ground'. Carr (1986) suggests that engaging the practitioner in the research process is a common sense development in terms of practice-based research, because it acknowledges the practitioner's intuitive sense of what works in practice while at the same time challenging this knowledge as new ideas about the field emerge. My interpretations of the descriptive map are presented in chapter eleven of this study.

Thorne (2008) believes that the practitioner-researcher undertaking the interpretive description study must make available his/her research of the clinical phenomenon to practitioners working in the field. In terms of this study the descriptive and interpretive findings are developed, in the conclusion chapter, into a list of practice statements that will be of value to practising arts therapists. This idea links into the NHS Quality Improvement Scotland (2005) Best Practice Statements (BPSs) initiative in which BPSs are developed by the practitioner-researcher who wished to better understand his/her clinical area. Information on practice is gathered from the "best available evidence" (Quality Improvement Scotland, 2005, p.2) for dissemination among practitioners and those working with them.

Philosophical alignment of interpretive description

Interpretive description recognises the "contextual and constructed nature of the human experience that at the same time allows for shared realities" (Thorne et al. 2004, p.5). In this study I was interested in how the descriptive accounts of the arts therapists and the medical/care staff working alongside them were constructed and how I interpreted their experiences. Interpretive description situates itself within the naturalistic interpretive paradigm (Lincoln and Guba, 1985). Increasingly, the paradigm has been characterised by methodological integration. Thorne et al. (2004) have suggested that in order to capture the themes and patterns underpinning clinical knowledge a more methodologically pluralistic approach is required. The idea has also been echoed by practitioner-researchers like Sandelowski (2000) and Lowenberg (1993). In line with this thinking this study adopts a pluralistic approach which is underpinned by some of the methodological principles outlined below.

Influences from grounded theory

Grounded theory is one of the most commonly used qualitative methodologies (Glaser and Strauss, 1967). The principles underpinning grounded theory centre on "the process of discovery and theory generation" (Willig, 2001, p.32). The techniques used in grounded theory help the researcher move from the grounded (in the field) responses of participants towards theory generation and abstraction (Glaser and Strauss, 1967). A principle from grounded theory informing this study is the notion that a research project should take place even when there is limited (published) knowledge of the field. The researcher should not worry if there are not a specific number of participants but he/she should move with the changing circumstances of the research and adapt his/her study accordingly. Grounded theory reminds us that research is not a static process but one that is dynamic and continually evolving as new knowledge is discovered. In this study I spent a lot of time moving backwards and forwards between the participants, data collection and analysis (discussed more fully in procedures and methods section). In this way the study was always, in line with the principles of grounded theory, grounded in the participants' perspectives.

There were aspects of grounded theory that sat apart from the interpretive description. In Glaser and Strauss's (1967) original version of grounded theory there is an underlying assumption that the researcher enters the study with no *a priori* knowledge of the field, that he/she suspends any awareness he/she has of any existing knowledge about the topic area. This is something that this study could not claim. The postmodern version of grounded theory developed by Charmaz (2006) (which was an early methodological consideration for this study) also recognised that it is not possible for the researcher to suspend all his/her existing awareness of the topic area. However, the method advanced by Charmaz (2006) does acknowledge that *a priori* knowledge is used only as a point of departure, something again this study could also not fully claim. The reason for this is that some of the research questions underpinning this study are descriptive; they aim to address specific aspects of arts therapy practice (e.g. referral, assessment and evaluation procedures). In grounded theory the aim is to produce research questions that emerge during the course of the research.

Grounded theory approach offers limited scope for reflexivity as its main aim is generating theory. Maheu (2005) and Stewart (1998) make the point that interpretive description may involve some theory generation but this is not its 'raison d'etre', rather interpretive description "aims to produce a synthesis of the main themes and patterns of the phenomena" (Maheu, 2005, p.55).

Influences from hermeneutic phenomenology

Hermeneutic phenomenology has influenced the interpretive element in this study. Phenomenology is concerned with human lived experience (Van Manen, 2008) and hermeneutics with the act of interpreting (Heidegger, 1927). The collaborative properties of hermeneutic phenomenology afford the researcher the opportunity to witness the lived experiences of the participants' as they encounter them. These experiences are then reflected upon and interpreted by the researcher.

Hermeneutic phenomenology did influence this study; during the placement visits I recorded my observations and interactions in the care setting as they were happening. I then returned to these and interpreted them (see s*etting observations*

section in chapter eight) Moreover, the integrative process by which I interpreted the descriptive map did borrow from this methodological tradition. The study, however, could not claim to be fully partisan to the hermeneutic phenomenological tradition because the primary goal was to create a descriptive map of the field. Researchers attempting to map a field seek out many pathways, whereas researchers wising to singularly employ principles from hermeneutic phenomenology in their research are more interested in describing and find meaning in the intricacies of the single pathway.

Influences from ethnography

There was an ethnographic strand to the study. Creswell (1998, p.10) observes that; “ethnography is (concerned with a) description and interpretation of a cultural or social group or system.” Through studying the group the ethnographic researcher learns of the patterns and behaviours that inform the group. Many methods used by postmodern researchers come from the ethnographic tradition (participant observation, reflexivity). An important part of the study was the participant observations undertaken in thirteen clinical settings. The visits allowed me to construct an important visual picture of where and how the arts therapists worked and what the issues were that impacted upon them. In writing this study I also have borrowed from the ethnographic tradition. Geertz’s (1973) *thick description* has influenced the descriptive style in which this has been written.

Some areas of ethnography that were not applicable to this study were the use of the ideational and materialistic theories that underpin cultural theory. I was not immersed over a long period of time in the care settings so I did not undertake a detailed study of the behaviour, language and interactions happening in the care settings that I visited; I was more interested (due to time restrictions) in obtaining a snapshot of the different clinical cultures. For a more longitudinal view of the work, I relied on ongoing discussion with participants (outside of the setting context) combined with my own knowledge of working as an art therapist.

Reflexivity

Reflexivity emerged from the ethnographic tradition. Reflexivity is defined as "thoughtful self-aware analysis of the intersubjective dynamics between researcher and the researched" (Finlay, 2003, p.ix). Lowenberg (1993, p.59) suggests that the "interpretive research perspective recognises the importance of the interpretive processes of the researcher in all the research undertakings." A reflexive researcher acknowledges personal influences. Finlay (2003) believes that all qualitative researchers must be engaged in some form of interpretation because to avoid doing so renders the research pointless, just another piece of "realist repertoire" (Finlay, 2003, p.30). Wilkinson's (1988, p.55) multi-lens approach to reflexivity offered a potentially decentred way because it focuses on three different aspects of reflexivity 'personal', 'functional' and 'disciplinary.'

The 'personal' relates to the researcher and to her own identity, the interests and values that have shaped his or her own life in relation to the research process. For the researcher this means acknowledging who she is, what she believes in and what has led her to this research. For example, how the background of the researcher impacts on the decisions made during the study and how this knowledge provides a backdrop to the study. In considering the term 'functional' reflexivity Wilkinson (1988) suggests that it is closely aligned to the 'personal' reflexivity but relates more to questions of epistemology (Wilkinson, 1988). Two questions underpin functional reflexivity; the first asks how are the choices of methodology and method shaped by the researcher's own knowledge. The second question asks, how effectively does the research follow the epistemological ideals advocated by the researcher. Wilkinson (1988) believes that in order to address these two questions there needs to be a continual critical examination of the research process. 'Disciplinary' reflexivity relates to the need for the researcher to acknowledge the disciplinary knowledge that underpins the field under scrutiny.

Procedures and Methods

Overview

In this section I begin by offering an overview of the development of the study in terms of the changes that have happened during the research process. Ezzy (2002) and Flick (2002) remind us of the cyclical nature of qualitative research, one in which the researcher engages in a continuous review of the phenomena. This section also outlines the methods employed in the study.

The development of the research design

This was initially envisaged as a two-stage mapping study. The goal of the first part of the study was to delineate a first broad picture of who were the arts therapists, where and with whom they were working. Eight *key advisers* were to be interviewed in this stage of the study. The criteria used for identifying the sample of the key advisers was:

- UK trained arts therapists registered by Health Professions Council
- Arts therapists involved in lecturing on arts therapy postgraduate training courses or working in the practice setting as clinician trainers.
- Arts therapists who had researched and published in the field.

The goal of the second stage of the study was to gain an in-depth understanding of the *therapy work* undertaken by eight *practising arts therapists* (Table 10). Therapy work is defined as; the referral, assessment/evaluation procedures, theories/ theoreticians and methods informing arts therapy practice. The criteria used to identify the sample of *practising arts therapists* was:

- UK trained arts therapists registered by Health Professions Council.
- Arts therapists currently working with older people who had dementia.

Initially a set of descriptive research questions was envisaged:

- Who are the arts therapists, where and with whom are they working?
- How do arts therapists work in terms of their therapy work?
- What are the emerging patterns of practice?

Flexibility is part of the qualitative researcher's modus operandi (Robson, 2002). I found that ten *key advisers* were willing to take part in the stage one semi-structured (telephone and email) interviews (Table 10). Twenty-one practising arts therapists were willing to take part in the stage two semi-structured (telephone or face-to-face) interviews. Eleven of these were face-to-face interviews conducted during thirteen setting visits (two of the arts therapists worked in two different settings) throughout Scotland and England. The face-to-face interviews provided me with an opportunity to become a participant observer in the settings where the arts therapists worked. I was interested to see where the arts therapists worked in terms of the type of setting and the therapy space they used (I was not granted ethical approval to meet the clients whom the arts therapists worked with). This was also an opportunity to meet the medical/care staff working with the arts therapist. During these visits I undertook two formal and eight informal interviews with this group.

Table 10 – Arts Therapist Participants			
Discipline	Participants	Stage one	Stage two
AT	10	Romy Alexander	Pamela Thomas Helen Jasmin Kim Heather Sally Jenny
MT	8	Ben Emma	Claire Hope Orla Rebecca Louisa Michael
DMT*	7	Stella Freya Kate	Janice Grace Sarah Laura
DT	6	Heidi Beatrice Ray	Steven Susan Bernard

*In this study DMT were the third largest group of arts therapists

Following transcription of the initial ten interviews a brief thematic analysis (using the computer programme NUD*IST 6) was undertaken. The aim was to look for broad themes from the first set of interviews and use these to generate an interview schedule for the stage two practising arts therapists. It became clear during this process that the key advisers were not able to offer a broad picture of the arts therapies and dementia field because no such picture existed. This has yet to be fully understood. What the key advisers did speak of was their subjective experience of working in the field. All of the key advisers were practitioners apart from two, who were academics but had been practitioners. The key advisers had all written a chapter or an article about their own clinical work in the dementia field. They described themselves as practitioners who had published. The two academics were both involved in a series of wide-ranging research projects (with different

client groups) so their knowledge of this particular field was localised to specific pieces of research they had undertaken.

Another issue was that the field was so dispersed, that apart from one special interest group (Art Therapy Outlooks on Later Life, abbreviated to ATOLL). It was difficult to imagine how the key advisers would have any knowledge of how their colleagues worked. Instead what emerged was a group of individual practitioners talking about their own practice. It was at that point that I decided to abandon the idea of a two-stage study and to just have one group of participants. I decided to call them *arts therapists* and to analyse all the interviews together. In light of this re-shaping of the study, and the participants focusing on their subjective experience I felt that it was important to add a more interpretive type question to the existing descriptive questions. The final set of research questions were:

- Who are the arts therapists, where and with whom are they working?
- How do arts therapists work in terms of their therapy work?
- How do the arts therapists experience their work?
- What are the emerging patterns of practice?

The introduction of an interpretive question fits with the principles of the interpretive description study. Thorne et al. (2004) observe that the practitioner-researcher sets out to describe the practice phenomenon but finds that participants wish to engage in exploring their own subjective responses to their clinical work

Sampling procedures

Sampling is the process used for selecting participants for inclusion in a study. It is often said that qualitative researchers do not employ sampling procedures but Sarantakos (1998) believes this to be incorrect and that qualitative researchers should instead "employ sampling procedures which should correspond to the philosophy of this type of research" (Sarantakos, 1998, p.154). The interpretive description study draws upon purposive and theoretical sampling techniques

because both offer ways of capturing the “expected and emerging variations within the phenomenon under study” (Thorne et al. 2004, p.6).

Purposive sampling was employed at the beginning of this study and is used when the researcher requires a specific group of participants in order to represent best the aims of the research study (Sarantakos, 1998). Purposive sampling proved a useful tool in this study because it helped me to identify who I was looking for and through their identification to focus on a strategy for locating them. The arts therapy field is small and widely dispersed. Some participants were located by contacting the four arts therapy associations and requesting their professional directories, these contained the names of practising arts therapists. Not all the associations were willing to share the names of their registered arts therapists so advertisements were placed in the relevant discipline’s journal. Contact was also made with UK arts therapy training courses in the hope that recruitment posters could be displayed on their notice boards.

Several of the participants were recruited by word of mouth or snowball sampling. In snowball sampling the researcher contacts a small number of people from the relevant sample group and then uses these contacts to generate more contacts, thereby creating a snowball effect. Bryman (2004) says that one problem with snowball sampling is that it is very unlikely to be representative of a population. In this study my sample was my population. The reason why this was possible was because the field was small. I knew this from my knowledge of working in Scotland. I was one of only three art therapists working with older people who have dementia in Scotland. Applying my localised knowledge to the wider UK I realised that although the pool of participants in Southern England would be larger than Scotland, the overall pool would be quite small. After a year of recruiting, the same participant names were given to me so this suggested that the field had been saturated.

Contacting participants

Most of the participants made contact with me following the advertisement and poster recruitment campaign. When I did make initial contact with potential participants this was done by email or telephone. If participants were interested in

participating they were then sent an invitation letter, information sheet and consent form. A two-week 'cooling off' period was offered to participants to give them time to read the information sheet and think about any questions they might have regarding their participation in the study. After the two-week period I contacted participants, addressed any questions they had and asked them to return the consent form to me. A detailed ethical approval process was followed (this is discussed more fully at the end of this chapter).

Semi-structured interviews

Three different types of semi-structured interviews were employed in the study (Table 11).

Table 11 – Interviews Undertaken with Arts Therapists

Discipline	Telephone	Face to Face	Email
AT	Romy Alexander Pamela Thomas Helen Jasmin	Kim Heather Sally Jenny	
MT	Ben Emma Claire	Orla Rebecca Louisa Michael	Hope
DMT	Stella Freya Kate Janice Grace Laura	Sarah	
DT	Heidi Beatrice Steven	Susan Bernard	Ray

Semi-structured interviews are the most common type of interviews (Bryman, 2004). In semi-structured interviews questions emerge from vague pre-planned

topics areas which are adapted to suit the 'here and now' of the actual interview (Robson, 2002). The semi-structured interview is a frequently used tool because it is a straightforward and non-problematic way of collecting data. Robson (2002) suggests that the strength of the semi-structured interview lies in its flexibility. The fluidity of this type of interview structure affords the interviewer the opportunity to 'move' with the interview, to adapt questions to suit the pace and mood of the interviewee.

Semi-structured interviews were employed in this study. The interviews were done in two-stages. The first group of ten therapists (originally stage one) were interviewed in 2004 and the second group of twenty-one arts therapists (originally stage two) were interviewed in 2005. An interview schedule was developed based around five broad topic areas, before the first set of interviews. The aim was to use this schedule as a guide, however, the spirit in which participants were interviewed was as open as possible; participants were invited to move away from the interview schedule if they wished to speak about any particular issues relating to their practice. Following a brief thematic analysis of the first ten interviews, a further interview schedule based around six topic areas was developed. This was used as a guide for interviewing the second group of twenty-one practising arts therapists (Appendix B).

The arts therapists were given a choice of either telephone, face-to-face or email interviews. The reason for offering multiple methods of interviewing was because firstly, I wanted to offer the arts therapists a choice of how they were interviewed: this was in recognition that some participants feel more comfortable with one style of interview than another. My knowledge of the art therapists led me to believe that my participants might like a choice as to how they were interviewed. On the whole art therapists tend not to be receptive when only one option is offered. They can feel constrained by conformity. I envisaged that the same might be true of the other arts therapy participants. The second reason for offering multiple methods of interviewing was logistical; the participants were dispersed throughout the UK.

In discussing the different types of interviews Robson (2002) notes that the most common type of interview in qualitative studies is the face-to-face semi-structured interview. Face-to-face interviews are useful because the interviewer is able to

respond to the 'non-verbal-cues' of the interviewee and move with the pace of the interview. Bryman (2004) comments that when face-to-face interviews are not possible for the qualitative researcher then there is the possibility of telephone and online or email interviews. Sarantakos (1998) states that telephone interviewing became popular after the Second World War. The telephone interviews according to Sarantakos (1998, p.265) have the same “structural characteristics as standard interviewing techniques.” Robson (2002) suggests that with telephone interviews building up a relationship with the interviewee may be more complex but the advantage is that the interviewer will have less visual effect on the interviewee and therefore lessen the tendency towards “socially desirable responses” from the interviewee (Robson, 1993, p.282). Email interviews bring a different type of complexity. The written text replaces the visual and verbal cues of the face-to-face and telephone interviews. Robson (1993) says that the lack of person-to-person contact can have an impact on the motivation of the interviewee to participate in the actual interview.

Although only two email interviews were conducted during this study, I observed that they were different from the face-to-face and the telephone interviews in that they embodied a ‘crispness’ of style that led to a short direct “interview”. The face – to-face and telephone interviews shared a similar quality in that a question would be asked and the interviewee would begin by responding to the question but often move beyond the question to discuss a related issue or to recall a personal reflection which illustrated the point they were talking about.

All arts therapist participant interviews were tape-recorded. The interviews generally lasted for one hour. The participants offered me the opportunity of remaining in contact after the interview so that I could clarify any points with them. I took the opportunity to re-interview, by telephone, one of the email participants because I wanted to find out more about the methods she was using in practice.

Staff interviews

A further group for consideration with regards to the interviews were the medical/care staff who worked with the arts therapist (Table 12). Initially, it was envisaged that face-to-face interviews would be undertaken with consenting

members of the staff team during the setting visits. Medical/care staff were recruited through the arts therapist. Invitation letters, interview schedules and consent forms were sent to the art therapist to be distributed to any managers and medical/care staff wishing to participate in the study.

Table 12 - Interviews undertaken with Medical/Care staff		
	Formal	Informal
Unit Manager	Jean* Linda	Susan Glenda
Nurse/Nursing Assistant		Hilary Carla
Occupational Therapist		Fiona Amanda
Care staff		Agnes Mary

*No real names were used during this study

Only two managers consented to formal tape-recorded interviews (approximately ten minutes long) but all the managers consented to me speaking informally to medical/care staff during my visit to their setting. Eight informal interviews or conversations were undertaken with medical/care staff during my visit. These generally lasted five to ten minutes.

Participant observation

Ezzy (2002) rather beautifully observes that qualitative observation is best done when the observer becomes part of the dance. Stemming from sociological, anthropological and ethnographic traditions, participant observation rejects the traditional role of the researcher as objective observer, instead placing the investigator at the heart of the study as a subjective participant or *participant observer* in the research setting (Marshall and Rossman, 1999). The primary strength of participant observation is that it affords the participant observer the opportunity to take part in the lives of the people being studied and through this the participant observer learns “what different activities, relationships and institutions mean to them” (Mcleod, 2003, p.80).

Table 13 - Participant Observation Settings			
Discipline	Number of Settings	Type of Settings	Organisation
AT	5	Hospital x 2 Community residential x 2 Community residential	NHS Private Voluntary sector
MT	4	Hospital x2 Community residential* Community day unit	NHS NHS Voluntary sector
DMT	1	Hospital	NHS
DT	3	Hospital Community day unit Community residential	NHS NHS Private

*DMT participant also working in same setting

As a visual person and a person researching a profession concerned with relationships it felt significant that I should go and meet the participants. I visited eleven arts therapists in thirteen care settings (two arts therapists worked in two different settings). The selection of the care settings was random (Table 13). I asked all arts therapists currently working in the field if it would be possible to visit them. My aim was see where they worked, to see the therapy space they worked in, to meet the medical/care staff they worked with and to interview arts therapists face-to-face. I was not able to formally meet the clients the NHS arts therapists worked with due to ethical considerations (see the ethics sections for further explanation).

I set off one day in May 2005 in my car on a ten-day trip to visit the farthest away group of six arts therapists working in eight care settings (two therapists worked in two settings each). My travels took me all over England to day, residential and hospital care settings, run by state, private or voluntary sector employers. I later added to these first visits a further five visits in Scotland, where I also saw a diverse range of settings. The duration of each visit was anything from two and a half hours to one full day, depending on the work commitments of the arts therapist and the medical/care staff on the day I visited their setting. During each visit I spent time looking at the therapy space and observed the informal interactions that took place between the therapist, the clients and the staff. I tape-recorded my interviews with all eleven arts therapists and I undertook two formal and eight informal interviews (in the form of quick field notes) with members of staff.

During the visits I recorded my field note observations. I started by making some free-form notes just recording what I was experiencing as I stood in the care setting. I had also created a semi-structured participant observation sheet with key headings (Appendix C) to prompt my observations during my visits.

Analysis

Thorne et al. (2004) advocate that the researcher adopts a flexible approach to the analysis, one that is in keeping with the naturalistic interpretive paradigm. The writers suggest that the researcher avoids excessively detailed (line by line) coding of the transcripts and instead uses intellectual inquiry, asking questions such as; "why is this here?" "what does this mean?" (Thorne et al. 2004, p.13). Below I outline the analysis procedures that I used to create the descriptive map before moving on to discuss the process I employed to interpret the map.

Template analysis

Template analysis is a branch of thematic analysis that was developed by King (1998). Thematic analysis forms the base of most qualitative analysis, and is concerned with the identification of patterns and themes, often from interview transcripts (Holloway, 1997). Template analysis involves the researcher developing a coding template which contains hierarchical coding. The initial template is often conceived using *a priori* codes "which identify themes strongly expected to be relevant to the analysis" (King, 2005, p.1). Initial *a priori* codes are then employed, modified or dispensed with depending on their relevance to the emerging themes. The main idea is that an initial template is created that is then used as a guide for the emerging themes (King, 1998).

In terms of its philosophical orientation, template analysis occupies what King (1998) terms the middle ground in qualitative analysis. Analytical techniques according to King:

> "(Range) from employing template analysis in a more realist-orientated style similar to content analysis where all codes are *a priori* and analysed statistically, to using template analysis in a more relativist or contextual

> constructionist way where the analysis begins with a few codes but is largely emergent." (King, 1998, 118)

King (1998) believes that the reason a researcher may choose to employ template analysis over say constant comparative method of analysis used in grounded theory is because of his/her epistemological orientation. Glaser and Strauss's grounded theory emerged largely from the objectivist tradition, within a prescriptive framework, thereby setting it within a realist methodology. King (1998, p.119) states "that while practice and experience are also essential in developing skills in template analysis, on the whole the technique is more flexible with fewer specific procedures, permitting researchers to tailor it to match their own requirements".

In this study I used the basic framework of procedures outlined by King (1998) but I developed them around this study. My guide template was developed over a four-stage process (Appendix C)

The process began with me creating some open headings for the first interview schedule. These headings served as the initial template. King (1998, p.122) believes that "often the best starting point for constructing an initial template is the interview topic guide – the set of questions areas, probes and prompts used by the interviewer". After the first set of interviews I did a brief analysis of the transcripts using the computer programme NUD*IST 6. I coded the transcripts under the existing headings and added new headings as themes emerged. I then used the emerging template as a base for creating the second interview schedule. As already indicated I collapsed the two stages when I realised that my (original) stage one *key advisers* were speaking about their own subjective experience of working in practice rather than the broader field. The fact that the key advisers were speaking of their own practice meant that the template that emerged from their interviews could be used to create an interview schedule for the *practising arts therapists*. Following the completion of the second set of interviews, having decided to collapse the two stages, I began by analysing all the interviews together. In doing this I was interested in learning about: 1) the individual participant's background and journey into the field; 2) the practice issues that were shared by all the participants; 3) the practice issues that were specific to each discipline.

I began analysing all the interviews using the computer package NVivo (an upgraded version of NUD*IST 6) using my developed template as a coding guide. I sorted all the interview transcripts under the codes and began to develop new codes as themes emerged. It was at this point that I became frustrated with using the computer package because I felt that I could not 'see' the actual transcripts. I was developing a long neat list of codes with sub-categories behind which lay all the sifted transcripts. I needed a more visually accessible approach so that I could see what the arts therapists from the four disciplines were saying. I decided to dispense with NVivo and, in Microsoft Word, I began to create my own sub templates (Appendix D and E).

I took the headings for the sub-templates from the final guide template. Each sub-template was on landscape paper and had four columns one for each of the arts therapies disciplines. Under each column I added the relevant piece of transcript. In total I created thirty-seven sub-templates. Within each sub- template I developed lower, middle and higher order categories.

Once I reached a point of saturation with my sub-templates (I was revisiting the same pieces of transcript) I felt I had reached the point of "sensemaking challenged" (Chenail et al. 1997). I had deconstructed my *a priori* knowledge and had begun the process of "sensemaking remade" (Chenail et al. 1997, p.2). Having created a descriptive map of the field I wanted to develop some of the main themes that had emerged and explore their interpretive meaning. King (1998) advocates this approach. He observes that the final template does not signal the completed analysis but rather the start of the next phase of the analysis. He considers it "inappropriate to set out any general rule for how a researcher should go about the process of interpreting coded data; a strategy must be developed that fits the aims and content of (the) particular study" (King, 1998, p.130).

Interpreting the templates

Smith et al. (1999, p.51) suggest that; “toward the latter stages of the analytic process the researcher begins to involve him/her self directly in the research process in order to interpret the data and answer the research questions.” In line with the pluralistic principles underpinning this study an integrative interpretive analytic process was adopted in order to explore the experiences of the arts therapists. This process, particularly in the early stages, engaged with the potential of the unknown but later became grounded in a set of systematic procedures.

The process involved reading the templates, my participant observation notes and sometimes the original interviews in a free-flow manner. Smith (1999) suggests the researcher returns to the source material consistently to confirm that a sense of the original context is maintained. I used a large sheet of A4 card on which I noted anything of interest, words used by participants, my thoughts on what they were saying, anything that came to mind in that moment. I started to look for connections between the themes. Once I identified a potential connection I labelled it and began to build a category by listing all the relevant themes under the new label. One example, during this free-flow analysis, was that I began to notice the language that the arts therapists used when they talked about their experience of the work. I noticed that often the words used to describe how they felt about the work mirrored the words they used to describe how their client was feeling (Table 14).

Table 14 – Interpretation of Mirrored Responses

Older Person	Arts Therapist	Interpretation 1	Interpretation 2
Feeling disconnected Isolation/Loss Depression Trauma Confusion	Need for acceptance Professional isolation Stress/pressure Distress Not knowing	Being unheard	Power dynamic

I began to think about the notion of power dynamic in the setting. Who did the arts therapist need acceptance from? Why were they feeling professionally isolated? It struck me that there was a different culture in operation in the care settings, one that was driven by a different set of practices. This often appeared to leave the arts therapists with a feeling of "being unheard" (interpretation 1). I went back to the templates and to some of the actual transcripts to see if this was a common feeling. When I found that this was a shared feeling I accepted the label. The full list of themes emerging from this part of the study is presented in chapter eleven the interpretive chapter.

Establishing trustworthiness

The quality of qualitative research has been a hotly debated topic (Sandelowski, 2000). The complexity of the debate lies in the lack of consensus about the quality markers of qualitative research (Rolfe, 2006). One of the most recent and arguably widely used approaches to establish credibility in qualitative research has been the development of Lincoln and Guba's (1985) notion of Trustworthiness (an alternative to the reliability and validity advocated in empirical research). Thorne et al (2004) suggest that Lincoln and Guba (1985) and Sandelowski (1986) offer helpful procedures to guide researchers through the process. However, they believe that providing a "litany of attributes such as trustworthiness, transferability or making claims about one's integrity' (Thorne, et al. 2004, p.15) is not overly important because credibility will be established "largely from the way the specific analytical decisions are presented and contextualised within the larger picture" (Thorne et al, 2004, p.15). While the writers are critical of the "litany of attributes" (Thorne et al., 2004, p.15) associated with making qualitative research trustworthy, they do acknowledge that the practitioner-researcher must be transparent about issues such as power dynamics in the care setting and the practitioner-researcher's position within the study.

Within this context the study departs slightly from the thoughts of Thorne et al (2004). I found the guidelines offered by Lincoln and Guba (1985) helpful. Having not undertaken such a large-scale project before, it was useful for me to use the criteria offered by Lincoln and Guba (1985) to establish the congruency of the study.

Lincoln and Guba (1985) have suggested that there are four primary criteria for establishing Trustworthiness. The first is *credibility*, ensuring that the subject of the enquiry is accurately identified and described (Robson, 1993). This is achieved by allowing the 'social world' to have access to the research through techniques such as 'member checking', a collaborative approach where the researcher feeds back to his/her participants their interview transcripts so that they can comment on how they have been represented in the research. (Bryman, 2004). In this study *credibility* was achieved in three ways:

1) *Checking Transcripts*: A full copy of the each transcript was returned to all the participants for them to check. Participants were encouraged to comment on the transcripts. Any comments made by the participants were added to the transcripts and returned to the participants for a final check. This ensured that during the study there was an ongoing dialogue between the participants and myself. 2) *Visits to care settings* provided me with an important opportunity to see the care settings where the arts therapists actually worked. 3) *Involvement in the field:* I had one book chapter and one review published (Burns, 2006, Burns, 2007); I presented two poster presentations at national and international conferences; I did a conference presentation and professional talk. All of these provided me with important feedback opportunities.

The second of Lincoln and Guba's (1985) criteria is *transferability.* Transferability asks how transferable the research study is to other projects. This is often a complex question in qualitative research where the emphasis is on small-scale research. Bryman (2004) observes that qualitative researchers are encouraged to write *thick descriptions* (Geertz, 1973) in other words detailed descriptions of the findings that are transferable to other settings. This study contains thick descriptions of the arts therapists practice. Another way that transferability was achieved was through an increase in participant numbers. An estimated number of sixteen arts therapy participants were envisaged and this number was augmented to thirty-one. The increase in participant numbers created, I believe, a good representation of the whole population as sample and population became almost one. I knew this because through advertising the study widely in the UK (Northern Ireland and Wales included) the same names were being given to me.

Transferability was also achieved in that not only arts therapists were included in the study but also medical/care staff. This has helped to make the study transferable to other cultures and contexts. *Transferability* was also achieved through triangulation. The employment of different methods in the study helped the clinical phenomena to be viewed from different angles.

The third of Lincoln and Guba's (1985) criteria is *Dependability.* Dependability is concerned with the transparency of the research. What steps has the researcher taken to audit the project from both inside and outside the research domain? Dependability has been achieved through detailed discussion of research methodology. As part of auditing the study my director of studies and I spent time independently checking a selection of the interview transcripts to see if there was some initial agreement as to the emerging themes. The arts therapy participants were also given an opportunity to check and comment on their interview transcripts. Before doing this, consideration was given to the concerns expressed by Morse et al. (2005) that the researcher can become enmeshed in an appeasing relationship with the participants whereby findings are restrained in order to meet the personal concerns of each individual participant. In this study the arts therapists were very willing to share details about their work. At no stage did I feel I was engaged in an appeasing relationship.

The fourth of Lincoln and Guba's (1985) criteria is *Confirmability*. Confirmability is concerned with the researcher, asking has he/she 'acted in good faith' and not allowed personal beliefs or values to overshadow the research (Bryman, 2004). Robson (1993, p.406) suggests that *confirmability* asks, "have we been told enough about the study, not only to judge the adequacy of the process, but also to assess whether the findings flow from the data." The research has been scrutinised extensively by many people outside the research team. The nature of this study determined that research participants were located throughout the UK. In order to access the NHS participants and their settings, I had to approach nine different NHS trusts in order to have the study approved so that I could conduct the interviews/setting visits. Several of the trusts took the study through an independent peer review process.

Ethical considerations

My ethics proposal was reviewed by the Queen Margaret University College research committee. The committee advised me that because the study would involve some NHS participants I would need NHS MREC (multiple research ethics committee) approval.

Initially I wanted to include older people who have dementia in the study but it became clear to me that it would be very difficult to get approval from MREC if this was the case. The primary reason for this was concern over the dispersed location of the potential participants and how I would oversee the consent procedure for recruiting these "vulnerable adults". The second reason was time; the MREC committee concluded that I would have to go through many local research committees to seek local approval and as such I was in danger of running out of time to complete the project.

I received MREC approval in December 2004, which allowed me to recruit the NHS-based arts therapists and undertake participant observations in some care settings. Eleven practising arts therapists (from nine different NHS Trusts) contacted me and said that they would be interested in taking part in the study. I applied to all nine trusts for local approval. Each trust had different approval processes (some took the study through an independent peer review process, other trusts wanted me to have an honorary contract) particularly in respect of granting approval for the visits to the care settings. In total the whole process took one year to complete.

The ethical approval process was more straightforward for non-NHS arts therapists. I contacted the voluntary and/or private setting and asked for written permission to visit or telephone the arts therapist. Having received permission I went ahead and interviewed the arts therapists.

Chapter summary

Table fifteen outlines the research methodology underpinning this study.

Table 15 – Overview of Research Methodology	
Ontology	A relativist ontology informs this study. Acknowledgement is given to the *a priori* knowledge of the practitioner-researcher but an underlying assumption is made that the perspectives of the participants will inform and re-shape this pre-existing knowledge and create a different understanding of the clinical field.
Epistemology	Naturalistic Interpretive paradigm is concerned with multiple constructed realities that inform the participants. The participant and the researcher come together to create an understanding of the phenomenon being studied.
Methodology	Interpretive description is an inductive approach. The practitioner-researcher is concerned with constructing a descriptive account (in this study called the *descriptive map*) of a clinical phenomenon. Moving beyond the purely descriptive, the approach advocates that the practitioner-researcher interprets the meanings emerging from descriptive account in order to render a full understand of the clinical phenomenon.
Sampling	Purposive and snowballing sampling.
Methods	Semi-structured interviews and participant observations.
Analysis	Template analysis and integrative interpretive analysis.
Assurance of quality	Establishing a means of trustworthiness.

Chapter Seven

Professional Background of the Arts Therapists

Overview

There is no clear indication of who the arts therapists are in terms of their professional background, their prior training and career, how and why they came to work in the arts therapy and dementia field. Furthermore, there is no understanding about their current work status. These questions are addressed in this the first of the descriptive map chapters.

The descriptive map spans chapters seven to ten and offers a descriptive account of the analysed arts therapists, medical/care staff interviews and participant observations undertaken in the care settings. The headings used in these chapters are adapted from the final guide template.

The participants

Thirty-one arts therapists participated in the study, all coming from the four arts therapies disciplines of art therapy (AT), Music Therapy (MT), Dance Movement Therapy (DMT) and Dramatherapy (DT). In this study art therapists provided the largest group of participants followed by music therapists, then dance movement therapists and dramatherapists. The reader will note the change in discipline order (from that presented in the literature review) with DT switched with DMT this reflects the larger number of DMT, as opposed to DT participants that took part in this study (Table 16). In terms of gender of participants there was quite a significant imbalance with in total twenty-four female arts therapists participating compared with just seven male arts therapists: two from AT and MT; three from DT and none from DMT.

Table 16 – Profile of the Arts Therapist Participants			
Discipline	Number	Gender	Name *
AT	10	8 females 2 males	Jenny Pamela Kim Jasmin Thomas Helen Heather Sally Romy Alexander
MT	8	6 females 2 males	Emma Claire Orla Rebecca Ben Louisa Hope Michael
DMT	7	7 females	Kate Janice Sarah Laura Grace Stella Freya
DT	6	3 females 3 males	Susan Beatrice Bernard Steven Ray Heidi

*No real names were used in the study

I noted, during my search for participants, that there did seem to be a particular gender imbalance when it came to finding male therapists working with older people who have dementia. Freya (DMT), one of the participants in the study, did speak about this being a particular problem in DMT. She wondered if it was to do with the newness of the profession.

Training and career prior to becoming arts therapists

As mentioned in the introduction arts therapy training in the UK is at postgraduate level. All the arts therapists who participated in the study had a first degree. The situation differed among the care staff and managers I interviewed. The unit managers, like the arts therapists, had formal qualifications (e.g. primarily first degrees, often in nursing) while their employees, the care staff, did not have any formal qualifications.

In terms of the arts therapists, participants from DT and DMT had first degrees in a variety of subjects (Table 17). Interestingly, only two of the DT participants had trained in drama and likewise only two DMT participants had trained in dance while more than half of the participants from AT had a first degree in art or a related subject (six out of ten) and all MT participants had undertaken their first degrees in music.

The study revealed that participants from AT, DT and DMT had prior careers before they became arts therapists. The map illustrates that only Pamela (AT), Sally (AT) and Romy (AT) worked prior to their AT training in art-related professions (as art teachers). The remaining art-trained and non art-trained AT participants entered via a variety of different professions ranging from theatre costumier to community support worker (Table 17). DT and DMT participants who had studied drama and dance respectively remained in those areas, becoming a community drama worker, dancer and dance teacher, while the remaining DT and DMT participants, like their AT colleagues, entered via a variety of different careers (Table 17). The MT participants were the only group to both train and work professionally in music prior to their MT training. In fact only Orla (MT) and Hope (MT) worked as professional musicians before undertaking their MT training, while the remaining four MT participants went straight from their undergraduate training in musical studies to postgraduate training in MT.

Table 17 – First Degrees and Prior Professional Careers of Arts Therapists*			
Discipline	Name	First Degree	Prior Career
AT	Jenny	Art	OT technician
	Heather	English literature	OT technician
	Pamela	Social anthropology	Art teacher
	Thomas	Art	Support worker
	Sally	Art	Art teacher
	Helen	Anthropology	Anthropologist
	Kim	Textiles	Theatre costumier
	Jasmin	Social work	Unit manager
	Romy	Art	Art teacher
	Alexander	Art	Support worker
MT	Hope	Music	Classical musician
	Orla	Music	Community musician
	Claire	Music	Straight to MT training
	Michael	Musicology	Straight to MT training
	Rebecca	Music	Straight to MT training
	Louisa	Music	Straight to MT training
	Emma	Music	Straight to MT training
	Ben	Music	Straight to MT training
DMT	Kate	Languages	Translator
	Janice	Psychology	Book keeper
	Sarah	English and Drama	Hairdresser
	Laura	Psychology/social work	Social worker
	Grace	Dance	Dancer
	Stella	English	Researcher
	Freya	Dance	Community dancer
DT	Susan	Art and Design	Support worker
	Heidi	Anthropology/drama	Drama teacher
	Beatrice	Nursing	Geriatric nurse
	Bernard	Theology	Priest
	Steven	Education	Teacher
	Ray	Drama	Community drama

*Some details have been changed to protect the anonymity of participants

Training as arts therapists

The arts therapists were trained at higher education establishments throughout England and Scotland (Table 18).

Table 18 – Location and Year Arts Therapists Trained

Discipline	"Name"	Location of training*	Year trained
AT	Jenny	Southern England	2003
	Kim		1995
	Helen		1995
	Heather		2004
	Alexander		1999
	Romy		1970
	Jasmin	Northern England	2003
	Pamela	Scotland	1995
	Thomas		1998
	Sally		2002
MT	Emma	Southern England	1985
	Claire		1984
	Rebecca		1982
	Ben		2000
	Louisa		2004
	Hope		1990
	Michael		2004
	Orla	Middle England	2001
DMT	Kate	Southern England	1995
	Janice		1997
	Sarah		2001
	Laura		1995
	Grace		2001
	Stella		2001
	Freya		1998
			1970
DT	Susan	Southern England	2000
	Beatrice		1980
	Bernard		1997
	Steven		2002
	Ray		1996
	Heidi		1970

*Geographical locations are given in order to protect anonymity

In general the participants had primarily qualified as arts therapists between 1995 and 2004. However, there were some exceptions, for example Rebecca, Claire and Emma (MT) all trained in the 1980s and Romy (AT), Freya (DMT) and Heidi (DT) all trained in the 1970s. The findings suggested that the longest serving arts therapists worked with a number of different client groups. The reason for this was that often only short-term project work was available and when project funding ran out the arts therapists had to find alternative work, often with a different client group.

Reasons for choosing to work in the dementia field

I found there were five primary reasons why the arts therapists chose to work in the dementia field. Jenny and Heather (AT) and Susan, Beatrice and Ray (DT) had *prior professional knowledge of the client group*. They had worked previously with older people in their respective jobs as OT technicians, a social worker and as a community drama worker. As a result of this work they were interested in post arts therapy training and continuing to work with this client group.

> "I began to work using drama and dementia in 1994 as a community drama worker developing drama groups in a local dementia hospital… This work was pivotal to me when training as a dramatherapist" (Ray, DT).

Jenny (AT) and Kate (DMT) had *prior personal knowledge.* They had a family member(s) with dementia/associated illness. Both spoke about the deep impact of having a close relative with a progressive illness. Kate (DMT) talked about her frustration at the lack of activities available to her relatives in the care setting. Her desire to change this led to her training as a dance movement therapist.

> "I felt as if I had a fairly good idea of what was not there. There was very little available. I had a vested interest in doing movement therapy studies. My mission coming out of training was that I wanted to go and work in the elderly care setting" (Kate, DMT).

Orla (MT) chose to work in the field because she had a *desire to work with a new client group*. She spoke of her desire to broaden her clinical experience. The majority of therapists (nineteen in total; seven from AT; five from MT and DMT and two from DT) came to the field *by chance*. Rebecca (MT), for example, began working in the hospital setting and by chance she was invited to work in the acute

elderly and continuing care wards. While other art therapists, like Bernard (DT), heard about the work through word of mouth from another colleague. For some arts therapists, like Janice (DMT), it was the only job she could find:

> "I got the work purely by fluke. I didn't want to do it. I had suspected that I wouldn't be any good that I would be boring to older people or I would be too fast. I just thought our tempos were not going to be compatible. In the end I just thought I would try it and I went along" (Janice, DMT).

Five arts therapists in total, one from each of the AT, DMT and DT disciplines and two from MT, came to the work *through placement* during their arts therapy training. Grace (DMT) did not choose her placement with older people.

> "I was ill when everyone was choosing their placements and when I returned there was one left working with older people. I was really devastated. I wanted to work in schizophrenia or something similar. I was not happy but I went along and I realised this is amazing work, really fascinating" (Grace, DMT).

Susan (DT) on the other hand chose her placement specifically in order that she could work with older people who have dementia.

Current dementia work of the arts therapists

This section describes the current dementia work of the arts therapists. When I analysed the transcripts I found that some of the participants were *currently working in the field*, while some were *currently not working in the field.* Of those that were currently working in the field all were working on a part-time basis. This meant that most of the arts therapists had other jobs during their working week. I was interested to find out if these other jobs were in arts therapy work or non-arts therapy work. The category *current other work* emerged to take into account this diversified work.

Working in/out of the field

The work status of the participants was very much in flux (Table 19). Eighteen of the thirty-one arts therapists participating in the study were *currently in the field* while thirteen of them were *currently not working in the field* but they had worked

with the client group within the last two to four years. The reason for this state of affairs was that all the arts therapists worked in the field part-time.

Table 19 - Current Work Status of Arts Therapists

Discipline	Currently *out of* Field	Currently *in* Field	Mode of Work PT/FT
AT	Pamela Jasmin Thomas Helen Alexander	Jenny Kim Heather Sally Romy	PT
MT	Ben Hope	Emma Claire Orla Rebecca Michael Louisa	PT
DMT	Kate Stella	Janice Sarah Laura Grace Freya	PT
DT	Beatrice Steven Ray Heidi	Bernard Susan	PT

There were many variations of part-time working. For example, one arts therapist could work part-time in one setting, while another could be working in several settings offering one or two sessions per week. It depended on the terms of the arts therapist's employment contract. I found that the art therapist, dance movement therapists and dramatherapists were employed in either a part-time permanent or self-employed capacity while all the music therapists were employed on a part-time permanent basis. One reason for the music therapists' increased employment security was that one of the MT training trust was also an employer of music therapists and as such was able to contract the music therapists out to various care settings.

Other music therapists, like Orla and Rebecca, found permanent contracts within the NHS, while their AT, DT, and DMT colleagues tended to work in more of a mix of voluntary, NHS and private settings. This led to them undertaking more of a mix

of short-term sessional (minimum three months) and long-term (permanent) contracted work.

> "The art therapist here took some time out to do research so I was invited to take over her work and then eventually I was offered a permanent contract for 2 ½ days a week" (Bernard, DT).

Table 20 – Employers of Arts Therapists

Discipline	Permanent Contract	Employer	Self-Employed	Employer
AT	Pamela Kim Jasmin	NHS NHS Social Work	Jenny Thomas Helen Heather Sally Romy Alexander	Private Home Dementia Society Dementia Society NHS/endowments Private Home Dementia Society Dementia Society
MT	Emma Claire Michael Orla Louisa Rebecca Ben Hope	NHS NHS MT Trust NHS NHS NHS NHS MT Trust		
DMT	Kate Janice Laura Grace Stella	NHS Education NHS Social Work NHS	Sarah Freya	NHS Private Home
DT	Beatrice Steven Ray Bernard	NHS NHS NHS NHS	Heidi Susan	Dementia Society Private Home

Heather (AT) was self-employed (Table 20), funded purely by annual endowments donated to the NHS trust where she worked. She did not know year on year if she would still have work. Self-employed arts therapists, like Heather and Jenny (AT), tended to undertake short-term arts therapy work. The reason for this was that they, rather than their employers, had initiated the work. Self-employed arts therapists often found work by 'cold calling' the setting.

> "I created a leaflet which I followed up by 'cold calling' the manager. This was followed up by going to the setting and explaining what art therapy was. I had to make quite a lot of calls to get one home" (Jenny, AT).

The primary reason why thirteen arts therapists were no longer working in the field was related to funding. Arts therapists from AT, DT and DMT who had been trained for more than five years tended to move in and out of the field as and when funding became available.

> "I am not currently working with this client group. There was a high level of interest from the staff in the work but unfortunately the work ended when the there was a change in management" (Beatrice, DT).

Some arts therapists from AT, DMT and DT who had trained within the last five years went straight from postgraduate training into part-time dementia work and had remained in the field. Participants from MT who had been trained for more than five years tended to be more static and stay continuously in the field pre and post five years. For example, Rebecca (MT), Emma (MT) and Claire (MT) had been in the field for over ten years (Table 20) while amongst AT, DT and DMT combined, only Kim (AT) worked continuously in the dementia field over the same period. The reason given for not staying longer in the field was primarily that they were involved in short-term work where project funding had ended. A second reason was related to the arts therapists' personal circumstance/choice. Kate (DMT) for example, had to give up her work when she relocated while Pamela (AT) had given up work because of the demands of the job.

> "The art therapies department as a whole was being undermined by accountants and managers in the trust there was a lot of demoralisation. The woman who employed me in the trust found her job under threat so there was a lot of undermining of ourselves as a supportive group of therapists so basically my support started to go…I got very stressed…I couldn't cope with the job. It touched a button in me and I had very little support. I thought this is just not worth it. I think I have got burn out"
>
> (Pamela, AT).

Ben (MT) similarly had given up the job because of 'burn out' and Orla (MT) was thinking about giving up the work because of professional isolation. All NHS arts therapists working in Scotland, like their colleagues working outside the NHS, were lone practitioners, in the sense that they were the only arts therapists in their

respective setting. In the absence of other arts therapist colleagues the participants interviewed who were working in the NHS in Scotland worked largely alongside medical staff and other Allied Health Professionals (AHP), while those working in community day/residential settings worked with care staff. The findings suggested that five of the NHS-employed arts therapists working in England were part of larger arts therapy teams. However, most of the arts therapists currently in or out of the field had worked on their own (with medical/AHP staff or care staff) and not as part of an arts therapy team.

Other therapy work

I found that a diverse range of *other therapy work* was undertaken by the arts therapists, for example, Orla (MT) and Sarah (DMT) spent part of the week working in the hospital setting with older people and part of the week working with children in community settings. Heather (AT) and Grace (DMT) combined their dementia work with working in a forensic unit while Freya (DMT) combined her dementia work with working with people with learning difficulties and those experiencing drug and alcohol related problems. Hospital-based art and music therapists Kim (AT) Rebecca (MT) and Orla (MT) worked with different client groups within the hospital, so their dementia work formed only one part of their input into the hospital. For lone working arts therapists like Orla (MT), her remit was the whole hospital, even though she worked part-time.

Other non-therapy work

Arts therapists undertaking *other non-therapy work* were involved in a variety of different types of work. This work could be dementia or non-dementia related work such as academic work; lecturing, researching and supervising or working more in practice; as care staff/other agencies trainers in therapeutic (although not directly in therapy work) ways for working. Bernard (DT), for example, trained AHPs working with older people in *lifestory work*. Lifestory work involves the person's life history being written down by the witness/recorder. Sally (AT) on the other hand split her week between undertaking AT group work with some of her dementia clients and what she termed "cognitive activity sessions" (doing puzzles, playing games) with her other dementia clients.

Chapter summary

- The findings suggest that AT, DMT and DT participants trained and worked in a variety of different, primarily helping, professions before doing their postgraduate arts therapies training.

- Music therapists primarily went straight from undergraduate music training to postgraduate MT training without working in a different profession.

- Post training the decision by arts therapists to work in the dementia field was often ad hoc with only a few (five out of thirty-one) arts therapists choosing specifically to work with this client group.

- The work status of the arts therapists was often very much in flux. Eighteen of the arts therapists were *currently in the field* while thirteen of them were *currently not working in the field* but they had worked with the client group within the last two to four years. One reason for this was the part-time/sessional nature of the work.

- Once in the field music therapists tended to secure permanent NHS employment while the other arts therapists, particularly art therapists, undertook short-term/sessional and some permanent work in health care settings. The part-time/sessional nature of the work meant that arts therapists often undertook other therapy or non-therapy work to supplement their income.

Chapter Eight

The Client and the Dementia Care Setting

Overview

The previous chapter established that the arts therapists were working part-time/sessionally in a number of different health care settings. In this chapter I move on to discuss where and with whom arts therapists are working. The chapter begins with some general observations from my visits to the care settings. Consideration is given to arts therapists' perceived understanding of the psychological and emotional issues impacting on their client(s) and if biomedical factors such as the person's type of dementia are important. The chapter concludes with a detailed description of the care setting, the therapy space and the care setting issues that impact upon the arts therapists.

Observations from my visit to the care settings

In May 2005, I set off for ten days to visit the first group of settings. My journey took me all over Southern England. During the visit I interviewed six arts therapists working in eight different settings (two of whom were working in two settings each), saw the settings and therapy space where they worked and met the medical/care staff who work with them. This initial journey was followed by the Scottish part of the trip when I visited a further five arts therapists working in five different settings. In total thirteen settings were visited.

Initially, I was quite sceptical about how valuable the setting visits would be. I was slightly put off by the endless forms I had to complete in order to secure ethical approval from the specific settings to visit the NHS participants in particular. I had spent my career working in different care settings and I wondered how different these settings could be from the ones I had experienced. I did find the settings different, each one was unique: from the large Victorian hospitals, to a converted rural manor house with wonderful sea views but less wonderful interior, to the cosy

seaside town nursing home at the end of a cul de sac, to the inner city residential home surrounded by six foot high fencing. Each setting had its own characteristics.

> "The unit was enclosed with fencing. Entry to the unit was through the 'prison' gate. The manager sits in an office at the entrance and acts as gatekeeper. I feel like a prisoner" (Setting 2R2).

This observation is from an inner city setting that I visited. There was a forensic unit opposite with even higher fences. All the residents could see if they looked out of the window was fencing. Inside the setting there was no noise, no hustle and bustle of people moving around, nothing. The manager later said to me that the arts therapist was valued in the setting because he "brought some life to the place" (Jean, setting 2R2).

The lifelessness of some of the settings was striking. One of my most vivid memories was standing in the corridor of a hospital ward near to the nurses' station. The clinical staff stood behind the station writing notes and discussing patients. Just off the corridor was an open TV room where most of the older patients were sitting. The TV was on full volume and nobody was watching it. They could not because their chairs were facing in the wrong direction. Instead a sea of crumpled faces sat looking out into the empty corridor. I stood alone in the corridor looking back in. I had a huge sense of us all feeling lost, mutually disconnected from the world behind the nurses' station. Some of the settings gave me a similar feeling. I found the medical/care staff always helpful but in that type of environment it is hard not to become caught up in the routine of doing something for the person rather than being with him/her. It was hard to image these places as home.

> "Rooms are open plan. No doors, all glass walls. Undeterminable colour on the walls which gives the room a municipal rather than relaxing feel" (Setting 1S1).

One setting had been purpose-built for older people with dementia. Shaped into a perfect figure of eight so "the wanderers" never meet hard edges but it had no warmth, all easy wipe walls, chairs and pictures. In another I felt very upset by the shabby, tatty, windowless environment. This had been one of the more difficult visits to arrange, not because of issues around ethical approval, but I later reflected, perhaps because there was a collective sense of shame about the environment.

Interestingly, in this grim environment some valuable inter staff and client alliances were formed. There was a strong OT/AT alliance and together they were trying to change things. In fact in all the environments I was met by helpful arts therapists and staff who were more than willing to show me around and spend time talking to me about where and how they worked. Despite some of the settings being grim these were counterbalanced by some wonderful settings, places which felt like real homes. I walked through the door of one residential home and felt a huge sense of warmth hit me. The manager welcomed me and took me to see the arts therapist. What interested me about this setting and some others that I visited was that I was not shown around the whole setting but just to the arts therapy room. I reflected on how *Personhood* was being maintained, the person's privacy was protected. A sense of respect for the people living in this home was being upheld. This particular home sat right in the middle of a residential cul de sac. The home felt immediately at the heart of the community. It had been well decorated in warm tones, lovely carpets and lots of pictures on the wall. There was lots of laughter echoing round the house. I found out later that the manager had been an hotelier in her prior career.

Psychological and emotional Issues impacting upon the person

The setting had an impact upon me. I wondered what were the perceived psychological and emotional issues the arts therapists felt impacted upon their clients. The literature highlighted that the person who has dementia experiences a complex range of psychological and emotional responses to their situation. These are often tied up with the person's subjective response to *the disease* and to the changing circumstances he/she finds him/her self in as a result of the disease. Across the disciplines the arts therapists identified *loss* as a major psychological issue faced by their clients. Helen (AT) spoke of the many losses experienced by her client.

> "She was aware, much more aware of her loss, oscillating between feeling acute grief to being calm. She was upper class, married to a successful husband. She had been deteriorating over ten years and I think that it caused them social embarrassment. I feel that she had hidden personal issues, which were now coming to the surface. Her distress seemed related to her early childhood. She presented distress over losing her public veneer, also distress at feeling that her husband no longer loved her and distress

> over childhood memories. It was very difficult. She had been a good decorator, seamstress and floral decorator and it seemed to me that she was aware she was less able than before" (Helen, AT).

Helen (AT) illustrated powerfully the multiple layers of loss that her client experienced. Loss of status and a feeling of low self-worth, loss of a 'normal' spousal relationship, childhood loss surfacing and a feeling of being de-skilled, de-skilled in the sense that the person's skills and knowledge were redundant and that his/her ability to make independent choices was taken away. In physical terms Stella (DMT) spoke about the older person's fear of falling and how that can cause major anxiety in this population:

> "The fear of falling is such a major anxiety that it can organise a person's whole movement pattern. An older person can spend so much time trying to avoid a fall that they forget how to move without an aid. Once they start to rely more and more on their Zimmer frame or stick their movement becomes much more restricted. I think that is where the arts therapies are valuable because they can help the person manage this fear" (Stella, DMT).

Sally (AT) spoke about the person's isolation and how he/she could feel *isolated* from family and friends because of his/her dementia. She spoke about seeing older people in residential care alone in their bedrooms or sitting alone in the lounge, surrounded by other people, but somehow unable to make that relational connection with those around them. After some time the person's confidence slowly ebbs away. Romy (AT) spoke about the ensuing *depression* that is often experienced by the older person:

> "I think that depression is a feature of dementia because people know everything that is happening to them. Everyone knows there is this glib comment about 'Oh, they don't know do they?' But they do, people do know! They may not be able to express it but the emotional capacity and emotional intelligence is always present. People develop other senses that they would not normally. They need different cues to be able to tune in to what is going on"(Romy, AT).

Rebecca (MT) spoke about working with a client who had lived with depression before his diagnosis of dementia. The gentleman carried with him many painful memories from active service in the Second World War, memories that were now bound up with the trauma of his recent diagnosis. The notion of past trauma being re-visited in the present was highlighted by Beatrice (DT) who discussed how memories of sexual abuse could be triggered during the traumatic period pre and

post-diagnosis of dementia. Beatrice (DT) said a person could be living in a constant state of trauma as past and present traumas are both re-experienced and experienced in fragmented episodes. In fact the fragmentation experienced by the person may lead to feelings of trauma, because memories are never whole, part of one memory collides with another memory leaving the person traumatised by their inability to connect memories. Claire (MT) talked about the kind of *limitedness or stuckness* that overwhelms the person when connections with self, other people or the environment can no longer be made. Michael (MT) believed that such feelings are compounded when the person is not given a 'space' in which he/she can express how he/she feels about things.

> "In our case meetings the team talk about how quite a lot of people don't have any 'space' at all just to say that they find it really difficult. They are always being looked after by someone so they can always rely on their carer or a member of staff to make sure they know where they are" (Michael, MT).

The arts therapists spoke about the *anger and aggression* experienced by the older person. Helen (AT) was employed to help her clients work through the anger that they were experiencing. She spoke about one client's 'uncontained' feelings which resulted in aggressive outbursts when he was out in the street but when he was in session he had a desire to gain control over his feelings through his image making (see chapter nine). Jasmin (AT) identified *unfinished business* as a key psychological and emotional issue. She felt that her clients brought with them a desire to process or *work through* events that had happened in the past in order to try and make sense of them in the present.

Arts therapists' biomedical understanding

The arts therapists placed little emphasis on a detailed biomedical understanding of the different types of dementia. The degree of dementia knowledge that the arts therapists had about their clients' condition depended on where they worked. In the hospital setting the arts therapists were more 'medically minded' and had more knowledge about the different types of dementia and the behaviours associated with the disease.

> "I just sometimes am told or read through the notes which say this is frontal lobe damage. Obviously, the best way of measuring how far or how much

> somebody is moving into dementia is just by looking at their behaviour and their memory recall. There are some ritualistic behavioural patterns that show the patterns of dementia" (Sarah, DMT).

In the hospital settings the arts therapists had access to medical staff who were able to discuss a client's particular diagnosis. In the community care setting the arts therapists had access to care staff who were more knowledgeable about the day-to-day care needs of the person. Some arts therapists found themselves working in either the hospital or community care setting with a mix of older people, some with organic and some with functional illnesses.

> "No, it is a mix. There are some people who don't have dementia. I would say later stages about one third. The people who don't have dementia are quite a small percentage under ten per cent and then it is mainly people in early to middle stages"(Janice, DMT).

Of the arts therapists working with a mixed elderly population, Janice (DMT) reported that predominately her clients with dementia came separately to her arts therapy sessions. However, Janice (DMT) did report that the two groups were mixed if it was felt there could be group compatibility or if funding necessitated that, for example, there was only room for one group to be run in the setting.

I was interested in the language that the arts therapists used to indicate their biomedical knowledge of the disease. I found that during the interviews only Sarah (DMT) and Kate (DMT) used the term *Alzheimer's Disease*. Emma (MT) and Romy (AT) discussed their clients with a dual diagnosis, mentioning that the person suffered from dementia and schizophrenia or dementia and bipolar disorder. For example, Emma (MT) spoke of working with clients who had a dual diagnosis (dementia and schizophrenia) and how such people were often placed on the dementia ward in the absence of other specialised care facilities.

The remaining arts therapists used the more generic term *dementia* when talking about their clients diagnosed condition. I reflected on this during the course of the research and wondered if the arts therapists were influenced by my use of the term *dementia* on the pre-interview information sheet and consent form. I had chosen to use the term after much consideration about the ongoing debates within the field; firstly the biomedical debate surrounding the employment of the umbrella term "dementia" as opposed to the naming of a specific type of dementia (e.g.

Alzheimer's Disease), and secondly, the psychosocial debate advanced by Bender (2003) that rejects the use of biomedical terminology, viewing it as deterministic.

When I addressed this issue with arts therapists the consensus was that there was a dislike of labels. Freya (DMT) said, "I don't like labels". For her this meant not dwelling on the specific type of dementia her client(s) presented with. All the arts therapists stated that they were more interested to meet their client where he/she was *at* rather than being concerned with the label the person brought with him/her.

During the interviews it was clear that the arts therapists were more knowledgeable about the progressive nature of the disease than the different types of dementias. Some art therapists discussed the different stages of dementia experienced by their clients. For example, arts therapists, like Beatrice (DT) did speak about working with clients in the early, middle and later stages of dementia. There were two main reasons for this. The first was linked to the type of setting where the arts therapist was employed. Different settings worked with people experiencing different stages of the disease. Secondly, the different stages of dementia had an impact on the type of therapy work undertaken (see therapy work section for more detail). In the transcripts I found that arts therapists from each of the four disciplines were working with clients experiencing all three stages of dementia, although their work was more concentrated around working with people experiencing the mid to later stages of the disease. Generally, I found that the arts therapists tended to have a policy of inclusion rather than exclusion. They did not like people being categorised by their stage of disease. Only Kate (DMT) and Bernard (DT) expressed any specific opinion about whom they would or would not work with. Both were reticent about working with people in the very advanced stage of dementia.

> "I think the arts therapies are very limited at the severe end of dementia, but it is possible. I have worked with that stage but I guess it is the concept of how you work" (Bernard, DT).

> "I have worked with people in the first two stages. I would not be able to work with clients who are bed ridden but virtually any person who is able to sit up and maintain eye contact" (Kate, DMT).

After the interviews I wondered why other arts therapists had not made mention of, say, the complexity of working with a person in the later stages of dementia? I

wondered if it was to do with the different *art forms.* From my observations, drama and dance are more reliant on physical movement (and often in the case of drama an integration of movement and verbal skills) than art and music, which are more localised in the sense that therapist and client could be working with the brush and paint or with the instrument that was in front of them.

Arts therapists and the care setting

Type of care setting

The arts therapists were primarily working in residential settings (Table 21) funded either by the NHS, voluntary or private sector. The second most common setting was the hospital, followed by work in community day units.

Table 21 – Settings Where Arts Therapists Work

Disci.	Community Residential	Employer	Hospital	Employer	Community Day Unit	Employer
AT	Jenny Pamela Sally Romy Alexander	Private NHS Private Volun. Volun.	Kim Heather	NHS NHS	Thomas Helen Jasmin	Volun. Volun. Volun.
MT	Louisa Ben Hope	NHS NHS Volun.	Emma Claire Orla Rebecca	NHS NHS NHS NHS	Michael	Volun.
DMT	Kate Laura Grace Stella Freya Janice	NHS NHS Volun. NHS Private Volun.	Laura Sarah	NHS NHS	Laura	NHS
DT	Susan Heidi Beatrice Ray	Private Volun. Volun/NHS Volun.	Steven Beatrice Bernard	NHS NHS NHS	Bernard	NHS

Across the disciplines arts therapists working in hospitals, like Claire (MT), often did a mix of ward (assessment, continuing/long-stay care) and out-patient work. For example, Bernard (DT) worked for a hospital trust, his office was based in the

hospital but he worked out in the community in an NHS funded dementia day unit. Laura (DMT) similarly worked with the client group in both the hospital and in the NHS funded community residential care unit. Kim (AT) was working in the hospital setting and also doing work with older people in the community in their own homes.

The geographical picture for NHS hospital employed arts therapists was slightly different in England than in Scotland. Five arts therapists working in hospitals in England worked as part of a team of arts therapists and because of this they had a more delineated role. The augmented number of arts therapists in the setting meant that each therapist could focus on specific wards in the hospital. Their Scottish counterparts, on the other hand, worked independently so their remit was the whole hospital.

> "I have worked with some people for five years. Maybe I have worked with them in the therapy centre and then I have not seen them for a couple of years and then I see them back on the wards which is a brilliant bridge because quite often they will remember the art therapy process. I feel like a bridge quite often because I work all over the place" (Kim, AT).

Rebecca (MT), who was based in an NHS hospital in Scotland, was working with clients from the hospital-based dementia day centre while also offering MT to the rest of the hospital's adult population.

Many of the voluntary and private sector employed arts therapists worked in a mix of different community settings. For example, Jenny was employed to run AT sessions in five different private nursing homes. All the voluntary and private sector employed arts therapists worked on their own.

Therapy space

The arts therapists were offering therapy in a variety of different spaces, from *sitting rooms, bedrooms, dining rooms, on the actual ward, in assessment rooms off the ward, in a garden, in multi-function rooms.* The therapy spaces I visited were as varied as the settings. Sally (AT) for the most part worked in the open communal areas of the unit she worked in. She gathered her group of regular clients around a central table and worked with them while other clients and staff continued with their daily routine. Kim (AT) worked in her hospital setting in three different spaces. She

undertook one-to-one work in a purpose-built private therapy room that she shared with other AHP colleagues, she offered group work in the lounge attached to the day unit and she ran a group from the tables situated at the bottom of the male assessment ward. Louisa (MT) ran sessions in a shared multi-purpose function space. The room, a put-up room, was constructed of wood panelling and sliding doors and was situated in the heart of a large fifty-bed residential unit. The space was gloomy despite a large glass door at the side of the room which led off to the garden. The room was of medium size, with musical instruments spread out around the room. Louisa (MT) said that she had to pack and unpack the instruments before and after each session in order to accommodate the other activities that took place in the room.

Orla (MT) and Rebecca (MT) had lovely rooms with views on to rolling hills. They both had enough space for all their instruments. Interestingly, every MT room I visited was situated in the heart of the setting. Rebecca was concerned about how much her colleagues and other clients were disturbed by the noise of the music coming from her room. She talked about the necessity of soundproofing and how this was difficult in older buildings like the one she worked in. However, I did speak to Linda the manager in Louisa's (MT) unit. She commented on how much she enjoyed hearing the music coming from the MT room. She said that she often stopped on her way between the units to listen to the music being played; "it makes my day," she told me.

In Sarah's (DMT) hospital setting I visited the assessment ward where she worked. The ward was light and airy but very busy with the coming and going of patients and staff. Sarah (DMT) had managed to negotiate along with the OT staff the use of one of the treatment rooms for DMT and OT sessions. I was interested to see the room after hearing about the negotiations that had taken place to secure the space. On entering the room, I found a very large, empty and quite drab room. Old, misshapen curtains were hanging from curtain rails round the room, the type that are found surrounding hospital beds. The room was situated in the heart of the ward and was entered through two swing doors. Sarah (DMT) put a flip chart board and laminated A4 notice on the door to ask people not to enter the room during sessions. At the beginning of a session Sarah (DMT) placed chairs in a circle in the centre of the room. Laura (DMT) said she found the hospital setting challenging.

> "The ward is more difficult, even just getting the space and defending it and getting people along can be more difficult. It just depends on the culture at the time" (Laura, DMT).

Susan (DT) worked in a multi-function room situated off the main lounge in her setting. There was a 'first come first use' room policy. For example, if the hairdresser or dentist arrived first they used the space; Susan (DT) then had to re-locate to one of the bedrooms. In the bedroom she would use the bed as a table for her props and materials. During the session Susan (DT) and her client sat around the bed.

Issues related to the therapy space

Only a handful of the arts therapists had their own 'dedicated' therapy space. By dedicated I mean spaces where instruments or art materials could remain week on week and did not have to be unpacked and packed away before and after each session. The majority of the arts therapists had to unpack and pack away their instruments, art materials and props before and after each session. All the therapy spaces used by the arts therapists were shared with other medical or care staff colleagues.

> "My space is a shared room (…) it has a lot of furniture which means that every time I have to move things and make it into a therapy space. Once I have done that it is ok but it would be a lot less hassle if I didn't need to keep re-setting, every time" (Emma, MT).

The comments made by Emma (MT) echo the problems faced by the majority of the arts therapists. Most spent their time pre-session moving furniture, screening off areas, putting up "please do not disturb" signs and generally adapting the space for the therapy session. Among the disciplines there were some specific issues. For example, for participants from DMT and MT the size of therapy space was a problem. Spaces were too small and overcrowded with furniture. Often there was not enough room to have a group moving around the room or the space was too cramped to accommodate a group plus instruments.

In AT the issue centred more around access to a sink, storage of images and art materials. The DT participants had the least problems with the actual functionality

of the therapy rooms. Only Susan (DT) reported difficulties week on week securing the same therapy space. Susan's (DT) experience appeared to be the exception rather than the rule. The findings suggested that generally the arts therapists used the same therapy space each week with their respective clients. The arts therapists believed that using the same therapy space each week was an important part of the therapy process. They felt strongly that part of their role was to create a *safe space* in which the therapeutic relationship could grow.

> "One of the most important things for me is to make the space safe"
> (Sarah, DMT).

A *safe space* was identified by the arts therapists as a physical and emotional space where the client(s) could feel 'safe' enough to participate in artistic expression, to share feelings freely with the arts therapist and/or group without fear of being judged or criticised. A 'safe space' was boundaried by time and location (e.g. therapy work takes place, where possible, at the same time, in the same place), a space which was confidential.

> "There is something about making it safe for people. I think when the space becomes too open this particular group of clients start to feel unsafe or under pressure and that is not helpful. I think that it is really important to try and get that balance between enough openness that they bring themselves, that they can initiate things (…) but not to feel so pressurised that they become inhibited or perhaps frightened that they are not succeeding in some way" (Rebecca, MT).

Rebecca (MT) spoke of the balance required to ensure that her client(s) feel safe in MT. She observed that in order to achieve this balance there has to be an established (trusting) relationship between herself and her client. This relationship can only be established, to her mind, if both feel secure within a confidential therapy space.

Unlike Rebecca (MT), I found that six arts therapists, Hope (MT), Bernard (DT) Beatrice (DT), Kim (AT), Sally (AT) and Laura (DMT) had begun to question the appropriateness of a confidential and boundaried therapy space with this client group. Laura (DMT) and Beatrice (DT) and Bernard (DT) reported that they enjoyed working with their clients in public areas within their respective settings. They felt that working in such an open space offered many possibilities for different types of

interactions (e.g. with clients, staff and family members). Bernard (DT) questioned the importance placed on establishing a boundaried space.

> "Therapists are very good at wanting to be boundaried (but) I am not always convinced that the world of therapy is quite like that. It is fine in one's training and I guess lecturers want to impress upon us the boundaries and guidelines so we start from that point" (Bernard, DT).

Hope (MT) talked of the need to have a more flexible working approach. She suggested that the boundaries of time and space felt less important with this client group. Her sessions were loosely planned and they were very much dependent on the client/institution as to the regularity of attendance. Hope felt that what was important was her presence and the continuity of the music. Kim (AT) similarly spoke about not always following boundaries, particularly with this client group. She gave an example of one client who began "out of the blue" to write during a session. He kept on writing and by the end of the session was still writing. She did not want to take the pen and paper away from him so she made arrangements with the client and the nursing staff for him to keep them. She felt that it was something very important for him, something that transcended the boundaries of the session. Jean, a unit manager, who had worked with therapists from both AT and DT, observed that art therapists could be more precious about the notion of a safe therapy space than dramatherapists. She felt that the dramatherapists had a more relaxed approach to boundaries and tended to join in more in the unit's routines, such as having lunch with the clients after the session. She noted that the art therapists made a point of coming and doing the session and leaving the unit. Art therapists made a point of not crossing therapy/non-therapy boundaries. Hilda said that she felt that the dramatherapist's approach fitted in better with this client group, people who were experiencing the early stages of dementia, because to her mind dementia has no boundaries and a person's ability to share his/her feelings cannot be limited to a therapy session.

Arts therapists' role within the setting

Achieving the primary building block of procuring a confidential therapy space proved difficult for many of the arts therapists. Several faced significant challenges in relation to this and within the wider context negotiating their role within the setting.

> "It is very flexible (here), I have had to kind of make my own boundaries really. I sometimes feel quite a bit of pressure from the manager above my line manager to work in a way that I would rather not work. (A way) which I don't think is a very therapeutic way of working. I realise the need to be flexible in a setting like this but I don't have specific times for my clients because they may be asleep or something else but I do feel the regularity of the sessions is important" (Louisa, MT).

The manager mentioned in the above statement was not an arts therapist. For many of the therapists the problem was that they were working with colleagues who had limited or no knowledge of the arts therapies, often in homes and units where there was an established 'culture' of how things were done. This collision of two different worlds seemed most apparent in the community residential care and hospital settings, particularly with regards to the issue of therapy space. Managers often had limited understanding of why the arts therapist might want a confidential space in which to work, in fact many managers and care staff were unsure about how arts therapists worked. One manager I spoke to said that she didn't know what a music therapist was until meeting the current one. She wondered why the music therapist had arrived at the unit and asked for a private space in which to work. The manager was under the impression that she was getting a music activity officer.

Such misunderstanding about the role of the arts therapists led to continued problems between arts therapists and medical/care staff. For example, the arts therapists reported that care staff and in particular nursing staff, would interrupt sessions to give people their medication or to take people out of a session for an appointment.

> "I struggled with trying to keep the space confidential while trying not to offend the staff (…). When I said, 'I don't want you here' they just didn't understand why the (issue) of confidentiality was important for people with dementia. 'What have they got to say?' 'What is confidential?' (Pamela, AT).

Pamela (AT) questioned how much understanding staff had about her role and her clients right to take part in a confidential therapy service. She reported that she continually felt under pressure to try and maintain a balance between providing a confidential therapy service for her clients while trying to maintain good relations with her colleagues. This was a constant struggle for many of the arts therapists. Janice (DMT) recounted how the cleaner in her setting had helped her bridge the

divide between herself and the care staff. She found it difficult to get the care staff to bring clients to the sessions and furthermore she was having problems with the staff not respecting the confidentiality of the therapy space. The cleaner observed that Janice and the care staff were constantly misunderstanding each other. He said she needed to tell the staff directly what she wanted instead of hoping the staff would realise she needed a confidential space and help with bringing her frail, elderly clients to the session. That was their culture. Janice took the cleaner's advice and the situation was quickly resolved.

For many arts therapists it was a case of trial and error negotiating their role within the setting. The medical/care staff in some settings did come to appreciate and respect the work of the arts therapists. This was a gradual process. In Sarah's (DMT) hospital setting she joined forces with the OTs and together they negotiated with the medical team that they could use their clinical assessment room for sessions. Sarah (DMT) reflected that she felt very honoured that the team were willing to move rooms. Commentating on the relationship between arts therapists and medical/care staff Sarah (DMT) observed that, *"we (arts therapists) are a breed unto ourselves",* that the idea of therapeutic boundaries can *"really get up people's noses"* as they wonder, *"who the hell you are."*

Overall, I found that problems arose primarily during the early introduction of the arts therapist into the care setting. There were two reasons for this. Firstly, the majority of arts therapists were working predominantly on their own in settings that had no previous experience of an arts therapist. Secondly, once the terms of the arts therapist's employment had been agreed, the arts therapist generally entered the care setting and began working with clients straight away. There was limited time to meet with and discuss their role within the setting, to inform colleagues about their work and to establish vital links with their new colleagues. It was interesting to contrast the experience of the majority of the arts therapists with the experience of a minority. Five of the NHS employed arts therapists worked within an arts therapies and/or AHP team. The arts therapists spoke of this being a supportive work environment, one in which there was a shared understanding about the nature of their work. This was demonstrated to me in one setting where two arts therapists working together presented their work to colleagues and patients at a conference they had helped to organise.

Chapter summary

- The arts therapists spoke about the complex range of psychological and emotional issues experienced by their clients as a result of having dementia. Foremost among these was the issue of loss. The person loses all that is familiar to him/her during the course of the disease. Loss can be accompanied by feelings of anger and aggression and a sense of isolation. One arts therapist discussed the issue of trauma. She suggested that the person could be in a constant state of trauma as past and present traumas are both re-experienced and experienced in fragmented episodes.

- The findings suggested that arts therapists were not interested in the biomedical labels used to describe the person. This was particularly the case in respect of the type of dementia that their client was diagnosed with. However, the arts therapists were more aware of the progression of the disease and how this impacted upon the person and therefore potentially the work. Two arts therapists, one from DT and one from DMT, expressed reticence about working with clients in the more advanced stages of dementia because of the person's limited ability to take part in the session. Overall, the consensus from the arts therapists was one of inclusion rather than exclusion. They worked with anyone at any stage of dementia who wanted to participate in the arts therapy session.

- In terms of care settings, arts therapists work in community residential, community day and hospital settings funded either by NHS, voluntary or private organisations. Often NHS employed arts therapists undertake a mix of work in the hospital and out in NHS community settings. The arts therapists all, apart from five working for the NHS in England, worked on their own. The five arts therapists worked as part of an arts therapies team.

- In terms of therapy space, the arts therapists participating in the study worked in a variety of different spaces within the setting depending on availability. The issue of finding an adequate therapy space was of particular concern to the arts therapists. The arts therapists often felt compromised in their ability to provide a secure and confidential space for their clients. Six

of the arts therapists questioned the importance of working in a dedicated therapy space. They believed that more communal working within the setting offered many possibilities for different types of interaction.

- The arts therapists reported many problems in relation to establishing themselves in the care setting. One of the primary issues was that setting managers and medical/care staff did not understand the role of the arts therapists. The arts therapists were generally the first to work in their particular care setting. This meant staff often had no prior knowledge of their work, for example the need for a private therapy space. This lack of knowledge led to constant misunderstandings between the staff and the arts therapists. Many of the arts therapists were trying to fulfil both their professional obligations as art therapists and trying to work within the confines of a different culture. Arts therapists who worked as part of an arts therapy team had less problems; they had strength in numbers and as result they were able to establish themselves more easily in the setting.

- For many arts therapists it was a case of trial and error in negotiating their role within the setting. However, once they were established in the setting the arts therapist could often find support from colleagues.

Chapter Nine

Therapy Work

Overview

The previous chapter highlighted the complex psychological and emotional issues that the person with dementia may experience. Recognition from dementia care specialist (Kitwood, 1997) that such issues impact upon the person has brought the arts therapies into the dementia care setting. This chapter describes the referral and assessment procedures, theoreticians and theories and methods (including the props, materials and instruments) and evaluation procedures that underpin arts therapy practice.

Referral procedures

Different referral procedures were adopted depending on where the arts therapists worked. In the hospital where Sarah (DMT) worked she would, for example, advertise her open DMT group on the ward activities notice board. Generally for closed group and individual work in the hospital setting the arts therapist would initially visit the ward, meet the patients and staff and tell them about their work. Referrals would typically be made on the basis of:

- Self-referral - the patient expresses an interest in attending the arts therapy session.
- The patient is identified by a member of staff as someone who particularly likes music, art, drama or dance movement type activities.
- The patient is identified by a member of staff because he/she has become withdrawn and uncommunicative and the member of staff considers that some arts therapy input might benefit the person.

In Orla's (MT) hospital setting once a patient had been identified she would set up a diary system on each ward to ensure that the ward staff and patients knew about the person's MT session. Orla (MT) also left referral forms with the ward staff

(these tended to be the standard forms used within the hospital) for any future patients that staff might wish to refer.

> "Basically it's me making contact with the ward staff. I go and talk to them about MT. Staff are changing all the time; there might be student nurses, and people's shifts change so it is a constant job. That is why I tend to home in on certain wards where the staff are more consistent. You have to try and go with consistent staff and get them on side, to get them to grasp something about what you are doing, or hold (the appointment) in mind even when it is in the diary. I have a referral system. I have a form and I go and get them to fill it in. I try and help them with reasons for referral (…). I spend an awful lot of time waiting for referral forms to come back" (Orla, MT).

I found during the interviews and setting visits that hospital based arts therapists such as Orla (MT) and Rebecca (MT) often felt very frustrated by the referral process. The reason for this was that they had to spend much of their time chasing up referrals and finding out why patients had not come to therapy. This seemed less of a problem in hospital settings where the arts therapists worked as part of an established arts therapy/Allied Health Professional team. Working together meant that they had more of a voice within the hospital and were able to promote their work, and therefore their referral procedure, through running arts therapies workshops for their medical colleagues. The result of this was that their colleagues were more confident about referring patients to the arts therapies service and were less likely to forget to tell the arts therapist if a patient was unable to attend a session.

Referral to an arts therapy session in a community NHS, voluntary and private care setting was more informal and diverse. For example, arts therapists who worked sessionally often had difficulty establishing a referral procedure (or not until they were well established in the setting) because the terms of their contract gave them no regular non-contact hours, a time outside sessions to meet with staff and clients. Basically they were paid by the hour and were expected to 'hit the ground running'. It was the care staff who would initially select clients for participation in the arts therapy session.

> "When I first went they were just helped into the session which was very uncomfortable but was needed in order for them to get an idea if they might want to attend therapy" (Janice, DMT).

Arts therapists on permanent contracts, like Louisa (MT) who was employed by the NHS to run MT sessions in a residential unit, had more opportunity to visit the setting and meet with clients and staff prior to the commencement of MT. Reasons for referral in the community setting tended to be the same as in the NHS hospital setting. However, I did find that a more flexible approach was adopted towards referrals in these settings. Kate (DMT) spoke of how her clients came to therapy each week by way of her weekly pre-session "check in" with anyone who was up and about in the unit. Likewise, Laura (DMT) described a similar referral process.

> "Well, I tend to go round here a bit before and talk with staff and see how people are (…) I see where people are at and invite them along and they might not come or they might say 'yes I will come' and with some people you have to leave it to the last moment (before asking them). Working on different levels really" (Laura, DMT).

Laura's (DMT) comment about leaving it to the last moment to ask her clients if they wished to come to therapy was shared by other arts therapists. The reason for doing this, Laura explained, was that some clients become very anxious if told too early about the DMT therapy session (asking the person to do something different to what he/she is currently doing). With such clients, the arts therapists found it easier to take them directly into the session and let them see the space and materials so that the client could decide if he/she wanted to stay for the session or not. Janice (DMT) had a different experience with her clients with less advanced dementia. They sat waiting for her car to arrive and would get up and begin making their way to the therapy room before she was in the door.

Another reason for these 'on the spot' referrals was that the arts therapists found it difficult to plan ahead because the client's circumstances could change from week to week. Someone may not be feeling well or may have an appointment. The arts therapists, also, found that such 'on the spot' referring very much fitted with their philosophy of offering an inclusive rather than exclusive therapy service. They wanted to offer everyone who wished to participate in therapy the opportunity to do so, as Kim (AT) explains:

> "I will ask everyone every week. Sometimes they won't come for a year and then they will suddenly surprise me. I think that it is really important to ask everybody including people in the later stages of dementia who are often in bed and unable to move. I still want to ask them to keep them part of the process" (Kim, AT).

Kim's sentiments were shared by many of the therapists, who generally felt very passionate about the issue of inclusion. For those permanently contracted to the setting there was no definitive therapy 'cut-off' point. Even for arts therapists working on a sessional basis, once they had started they tried to work for as long as possible with the person.

Referring the person to group or individual therapy

The arts therapists participating in the study undertook a mix of group and individual therapy with slightly more group work being undertaken by the DT and DMT therapists than their AT and MT colleagues. The reason why more group work was undertaken was because the arts therapists were working with clients in early but primarily the middle stages of dementia where group work was still possible. Moreover, group work was a popular option with service managers because it was more cost effective than one-to-one work. The general trend seemed to be that arts therapists across the disciplines did group work with people experiencing the earlier and middle stages of dementia but found that individual work was more beneficial for a person in the later stages of the disease.

> "As people deteriorated their ability to access group work just kind of went downhill. I would say for the majority of clients in the unit I found individual work to be the most effective way of working" (Ben, MT).

Individual work was perceived as more beneficial for clients in the later stages of dementia primarily because of the need for more specific one-to-one support during therapy. For example, the person might need the arts therapist to help him/her to use the art materials, instruments or props. If left in a group a person experiencing the later stages of the disease could become 'lost', unable to access anything that was going on around him/her. In relation to this point I found that the arts therapists were adapting *standard* practice to meet the needs of their dementia clients. Ben (MT) observed that his work with his dementia clients was different from his MT work with children. In his children's work he would start with individual work and move towards group working but with his dementia clients this process was reversed.

All the DTs apart from Heidi (who interestingly had worked the least with this client group) had a similar experience. They were doing predominantly more individual work than they would normally do with other client groups. Beatrice (DT) said that the tradition in dramatherapy had been towards group rather than individual work. Still, Susan (DT), for example, was working only with individual clients with dementia. The manager had requested that she work this way because she wanted the clients to have some one-to-one input. Susan was a sessional worker and this seemed to be a factor in the decision about group versus individual work and likewise with Grace (DMT):

> "(Group work) is not really my preference, I mean I have done one-to-one work and I was really fascinated by it but I used to find it difficult to get one-to-one work" (Grace, DMT).

Arts therapists, such as Grace, were often at the behest of their employers with regards to "*bums on seats"* as Janice (DMT) put it. Group work was more economically viable for some managers when funding issues were at the fore. In practice this could lead to group incompatibility and arts therapists were forced to take on a more activity officer type role in order to meet the diverse needs of the group. When this happened it could lead to real frustration among the arts therapists.

Only Sarah (DMT) and Orla (MT) used the terms *open* and *closed* group work to describe the type of work that they were doing. The remaining arts therapists used the more general term group work, without specifying the type. Generally group numbers were between five and eight clients, however, this number varied depending on the setting.

Duration and frequency of arts therapy sessions

Susan (DT) saw her clients every second week. She set up a two-weekly rota to accommodate the number of clients referred to her. Susan (DT) was the exception rather than the rule, all the other arts therapists saw their clients weekly. Like so much of the work, the duration of sessions was very much in flux depending on the needs of the client and the employment status of the arts therapist. There were some general patterns. I found that typically group sessions lasted anything from

one to two hours while individual sessions could last for anything from ten minutes to one hour. The general rule was that the more advanced the person's dementia the shorter the arts therapy intervention. The reason for this was that the person could perhaps only sustain ten minutes of concentrated interaction at any given time before becoming overtired or wishing to leave.

> "It kind of depends! Some people can only focus for five or ten minutes and either they fall asleep or they get up and say they want to go" (Susan, DT).

For Sally (AT), who was self-employed, the duration of the session was less to do with the client and more to do with the time pressure she felt under to accommodate all her clients.

> "Working with individuals I have to watch my time - if I spend too much with one person then someone else is being left out. If I am in their rooms I tend to spend up to fifteen minutes, not really longer than that unless someone is really distressed, because that is the only way I can get round" (Sally, AT).

The duration of the actual arts therapy work depended again on the client, his/her desire/ability to come regularly to therapy and on the terms of employment of the arts therapist. Self-employed therapists did more time-limited therapy due to funding. For example, Thomas (AT) and Helen (AT) worked for just three and five months with their respective clients. Therapists from DT and DMT did similar periods of work. Time-limited work was often defined by the funding period rather than by the needs of the person. Helen's (AT) story was not untypical. She was employed in a voluntary sector dementia day unit to work with a man who was increasingly becoming "difficult". Helen (AT) worked with him for twelve weeks. Inside the session the art making seemed to "hold" him but outside the session his behaviour was becoming difficult; he was becoming abusive and aggressive to people on the street. Eventually he was admitted to the local hospital for assessment of his future care needs. Helen (AT) and his family felt strongly that AT was benefiting him so she continued for a time to work, unpaid, within the hospital setting. The hospital refused to fund the continuation of the work.

The findings suggested that participants from MT, unlike the other disciplines, were all on permanent contracts so, as a consequence they had more flexibility with regards to how long a person could attend therapy for. Ben (MT) observed that he would see his clients for as long as possible. He commented that, "there is always

quite a natural turnover of clients in this type of setting". The longest that I could determine that one client stayed continuously in therapy was around three years. Naturally, each client-therapist relationship was unique and therefore the duration of therapy work depended on so many different factors such as stage of disease, the person's desire to participate, the hours the arts therapist worked and how long the work was funded for. Only Kim (AT) and Laura (DMT) had, rather exceptionally, worked over a ten-year period with some of their clients. The work was not continuous work but they had experience of working with some of their clients as their dementia progressed. Laura, for example, spoke of first meeting one of her client's in the community, in a sheltered housing complex where she worked. She then met the person again years later in the hospital and then in the residential care setting. Kim (AT) spoke about the value of having prior knowledge of the person. She felt that despite the person's altered state, just to have a different sense of the person was so important for re-establishing the therapeutic relationship during the later stages of the disease.

For many of the arts therapists, working with a person with a progressive illness like dementia meant that they worked with the person until his/her death. Emma (MT) spoke very movingly about this:

> "I have found that with a number of folks they seem to have a sense of when their death is impending and often in their last session, this has happened more than once, people have stayed for fifty minutes and not wanted to go. One lady said goodbye to all the instruments in the session… [It was] really moving…I could hardly believe it" (Emma, MT).

For some arts therapists the ending of therapy due to the death of their client was starker than the moving description given by Emma (MT). In Louisa's (MT) setting she found out when one of her clients had died by reading a message on the office notice board. A nurse would come in and write on the board the name of the person who had died.

Help from medical/care staff before and during sessions

I found that a number of the arts therapists received some form of help from the medical/care staff in their setting before and during sessions.

> "I would get help to put a client in a wheelchair because I am not cleared for lifting but then I would probably bring them and take them back in the wheelchair. If the client needed help walking usually at least one member of staff would help with that" (Susan, DT).

For some arts therapists a member of staff would work in session with them when they did their group work. The findings suggested that this happened in particular in DMT and DT group sessions. A member of staff did attend some AT and MT sessions. Orla (MT) for example, had a member of staff helping with the session, while Pamela (AT), Heather (AT) and Kim (AT) sometimes had a staff helper, however, this was less common in these disciplines. I reflected on why this was and concluded that it perhaps had something to do with AT and MT being more static, sessions were centred round a table or round an instrument. The more active nature of dance and drama could be a reason for the need for extra support to help run the sessions. Stella (DMT), for example, spoke about how important from a practical perspective it was to have *in session* help.

> "With clients who have severely restricted movement I think you need a helper who actually sits next to the person otherwise as a therapist you have to go and help each person individually and that can take the attention away from the group process" (Stella, DMT).

For Bernard (DT), his staff helpers (on occasions two members of staff joined the group) took notes and wrote up the story that was being developed by the group. Bernard (DT) felt, like Beatrice (DT), that including members of staff was an important aspect of the work because it established a bridge between the care setting and the therapy work. He acknowledged that this only worked if the staff helper had an open mind towards the session. If the person was open minded and had a positive attitude then his/her energy and enthusiasm could help to motivate clients to come and participate in therapy. Several therapists spoke about how valuable it was to have another staff member in the room as a kind of sounding board, someone with whom they could sit down with at the end of the session and get feedback from.

> "After the session I spend five or ten minutes with the nursing assistant asking how she felt the session went. That has been really good and she will initiate that. She will take a patient back and then come and sit down with me and discuss the session. It is really good, really valuable" (Orla, MT).

I was able to interview the nursing assistant who worked alongside Orla (MT). She talked about her participation in MT as being a "unique experience". Initially she had felt apprehensive about attending the sessions, believing that "she was not very musical" but had found that she really enjoyed working with the music therapist. She mentioned how good it was to work in a "different space" (she normally worked on the wards) and to see how the patients responded to something different.

Not all the arts therapist and staff member partnerships were as successful. Staff members were often assigned to the arts therapist in a rather ad hoc manner. Many partnerships were based on the fact that a member of staff just happened to be available on the day the therapist was in the setting. The selection of the staff member was therefore random. Several arts therapist commented that this ad hoc approach could be problematic for all parties because the person might not want to help out in a therapy session or the person was not able to attend certain sessions because of their shift pattern. Once in session the staff member could assume that he/she was joining an activity class and could therefore be quite demanding on the clients, for example telling them what to draw, what colours to use, making comments about the image the client was creating. Problems arose between the arts therapist and the staff helper when there was a lack of communication prior to the start of sessions. An example from an open therapy session I attended illustrated this point. It was clear at the beginning of the session that the staff member, although 'doing her job' of ushering the clients in and getting them seated, did not really want to be there. She sat yawning as the arts therapist facilitated the session. I asked the arts therapist later about her relationship with the member of staff. She commented that she was in a difficult position because she had no say in who was assigned to her but she needed help in the session. She tried always to include the staff member by telling her prior to the session what she planned and post session to ask for her thoughts on what had happened. I did ask if I could interview the staff helper. Initially the staff member agreed to be interviewed but when the time came to speak to her she was not available for comment.

Assessment procedures

Findings show that the arts therapists had a flexible approach to assessment procedures. Rebecca (MT) and Kim (AT) spoke of having a six-week initial assessment period while the remaining therapists did not specify a time period. Rebecca (MT) gave the following reason for this.

> "Officially I have a six-week period but in practice it would be very rare that I would decide that somebody would not be appropriate. It is just to keep that possibility open in case they are not fitting in or to give them a choice about not actually wanting to come here. It is up to them if they want to come or not" (Rebecca, MT).

The absence of a definitive initial assessment period stemmed from the ongoing debates about firstly, how can creativity be assessed? Secondly, how can creative work with older people who have dementia be assessed? The arts therapists often felt stuck between a rock and a hard place with regards to assessment. They felt strongly the weight of 'professional expectation' on them to assess their clients (despite the limited development of arts therapies specific assessment tools) yet they were fully aware of the complexity of assessing creativity and the double complexity of assessing creativity with an older person who has dementia. This ongoing debate was made acutely evident to me during the setting visits. After one visit I made a note "assessment is a hot topic". During the visit the arts therapist noticeably became tense when I asked her about her assessment procedures. In a quiet, almost apologetic voice she said that she had developed her own procedures because nothing seemed to fit. Louisa (MT) talked about her dislike of the term assessment. Rebecca (MT) and Laura (DMT) viewed assessment as a means by which their clients could be excluded from the arts therapy service when what they felt their clients really needed was to feel included for as long as possible.

Despite some strong feelings around the notion of assessment I found that all the arts therapists were engaged to some extent in formal or informal assessments with their clients. Perhaps less surprisingly, I discovered that the arts therapists working in the NHS were more willing to talk about their assessment procedures than their non-NHS colleagues. The reason for this was that, firstly, they worked in what I call an "assessment environment", one where they had become used to the notion of

assessment and secondly, they had more access to different types of medical and AHP assessment procedures.

On the whole arts therapists tended to use, to a lesser extent, *formal assessment procedures,* procedures adapted from within the discipline or from other AHP (primarily OT) practice, and more commonly *informal assessment procedures,* general procedures that perhaps the arts therapist may even have developed him/her self.

In terms of formal assessment procedures, I found it was only really the DT participants that commented on the use of these. The procedures came from general DT or other AHP (primarily OT) practice. Bernard (DT), Heidi (DT) and Beatrice (DT) spoke of using standard dramatherapy assessment tools such as Jennings' (1998) Embodiment-Projection-Role (EPR) model which refers to the degree that clients can engage in embodied, projected or role-playing tasks. Heidi (DT) spoke of using the Ritual Risk Assessment Model which looks at the person's repetitive behaviour patterns and his/her dependence versus independence during DT sessions. Heidi (DT) used Lahad's six-part story method to enable earlier stage clients to self-assess the different types of stories (cognitive, social and personal) told during a session. Steven (DT) extended the use of the six-part story method from assessment to therapeutic intervention within the main body of the therapeutic work (further discussed in the section on theoretical principles). Beatrice (DT) used Creek's (1997) OT activity analysis proforma to assess her clients' activity capacity. On reflection, I was unsure of the degree to which these mainstream assessment procedures were adapted by the dramatherapists in their dementia work. I did ask Bernard (DT) and he said, "it is difficult to say - I borrow elements from different models and adapt them according to the client."

A common feature of arts therapy practice is the taster session and although the arts therapists didn't mention the term 'taster session' directly to me, it is implicit in the work. Taster sessions are one-off sessions where the client and therapist can "assess each other" before beginning therapy work. The 'taster' involves the client meeting with the therapist, discussing (where possible) what therapy is about. For clients in the earlier stages of dementia this might mean setting some goals for therapy. All clients would be given an opportunity to take part in some practical art,

music, dance or drama session before then being asked (when possible) how they felt about the session.

There were several *informal procedures* adopted by the arts therapists during the initial assessment period. Orla (MT) spoke of how she assessed the responses to MT of her non-verbal dementia clients:

> "I break it down and look at how one person is responding to the music. Are they responding more to melody, or to the sound of a particular instrument so I know with particular people that if I start to play a tune normally they will respond" (Orla, MT).

Orla (MT) speaks of the different musical elements she looks at during this initial assessment. Using a similar process, the art therapist would observe how the person responds to and uses different art materials. In AT the arts therapist would observe the choices between selection and rejection of materials used. The person's sequencing of image creation, from the empty page, to the first mark, to the build-up of lines and shapes, to the choice of colour, to the point at which the person stops working on the image. The dramatherapist would observe the person's level of engagement in the story. He/she would consider if the person is actively engaged in the story, able to join the group, use props and engage with the role of the weaver in the factory. Or if the client was physically incapacitated, the dramatherapist would observe how the client engaged in the session; his/her eye contact; how attentively he/she listened to the therapist/group. In assessing their clients dramatherapists were not only interested in the person's physical responses but also in the emotional state of the person intimated through his/her verbal or visual engagement in the story or the role-play. Similarly, DMTs used the movement produced by their client as an indication of the mood state of the person.

> "The assessment we use is really observing how people move in their torso to their extremities. What is interesting to notice is that older people tend not to move their arms but in a dance movement session you tune in with people's experience of music so old songs for example stimulate the person's memory and suddenly it is a whole different body movement. Assessment is about recording that and being able to describe the person in quite a different way from how people with dementia are normally perceived as docile, angry people just sitting there doing nothing" (Stella, DMT).

Flexibility of assessment procedure was important with this client group. Each client responded differently to the art form so the arts therapist either adapted existing procedures or developed his/her own. Bernard (DT) for example, used a large cardboard tube, the kind found in kitchen roll, to assess his clients.

> "You get people to use it (the cardboard tube) in different ways and that is quite an interesting assessment tool because there does come a point in dementia when people can't…I am using it as assessment tool to check out how people manage the important stepping stone into the world of drama because drama is the world of "as if" so "can I use this as a star?" I am interested in where people go with that" (Bernard, DT).

Bernard's (DT) statement illustrates why informal assessment procedures were important. They were adapted to meet the needs of the person.

Theoreticians and theories

Integrative/eclectic theories

In theoretical terms all the arts therapists interviewed had adopted an *integrative/eclectic* approach. The first reason for this, as outlined in the literature review, is that the arts therapy field is underpinned by two distinct influences - *the psychotherapeutic* and *the artistic.* Susan (DT) and Rebecca's (MT) statements illustrate these influences:

> "My thinking is influenced by theories from drama, dramatherapy and psychodynamic thinking" (Susan, DT).

> "The art form underpins the work, but I maintain awareness of other psychological theories, particularly those that address the relationship" (Rebecca, MT).

All the arts therapists combined elements from both the *psychotherapeutic* and *the artistic, to* varying degrees*,* within their practice. The second reason was linked to the therapists' core humanistic belief that their work was based round the individual needs of the person.

> "My theory is eclectic. The thing is each person I see is so different and you can't impose a rigid framework which states, 'I am going to sit down and do this.' You have to ask what is right for the person and it might be different on a different day. You have to be so flexible and still hold a boundary within that" (Rebecca, MT).

Putting the *person* at the heart of therapy necessitated, as Rebecca (MT) suggested, the need for a multi-strand theoretical approach, one that could accommodate the individual needs of the person. The *psychotherapeutic, artistic, and other discipline* (a category that emerged to take account of other influences) theories and theoreticians underpinning the integrative/eclectic approach are discussed in the following sections.

Psychotherapeutic theoreticians and theories

Person-centred

The psychotherapeutic strand was comprised of two threads: 1) person-centred and 2) psychodynamic, including psychoanalytic influences. In terms of this study the arts therapists reported that the *person-centred* approach was their primary psychotherapeutic influence. The approach was used to varying degrees by the arts therapists; this meant that there were different trends in the way the approach was integrated by each discipline. The person-centred ideas espoused by the theoreticians Rogers (1951), Kitwood (1997), Prouty (2001) and were highlighted by the arts therapists.

Rogers

Carl Rogers (1951), the 'founding father' of the person-centred approach, was mentioned directly by Freya (DMT), while others from across the disciplines acknowledged him indirectly by referring to his theoretical model. Rogers' (1951) approach locates the arts therapist in the role of listener and reflector, someone who mirrors back to the client what he/she has revealed during therapy. The therapist primarily takes a non-directive approach, taking their lead from the client rather than making an interpretation of the client's verbal and non-verbal responses. The approach is centred round the core conditions of congruence, empathy and accepting and is often perceived as the basis for a number of different approaches,

such as Kitwood's (1997) Personhood model and Prouty's (2001) *Pre-Therapy* work and

Kitwood

Arts therapists from across the disciplines acknowledged the influence of Kitwood's, (1997) model of Personhood.

> "The work is client-centred. I developed a sense of the importance of the 'here and now' rather than specifically working with change and growth. Tom Kitwood's theory of Personhood enabled me to contextualise my approach within a broader theoretical framework" (Hope, MT).

Grace (DMT), for example, spoke of Kitwood's (1997) work on positive interaction. She was influenced by his bringing to awareness of the "I" "thou" position, which is concerned with meeting the person where he/she is at in the present

Prouty

Jenny (AT) referred to Prouty's (2001) *Pre-Therapy* approach. The model was developed for people with schizophrenia but has been used with other client groups. The approach is centred on establishing and maintaining contact with the person. Prouty (2001) suggests that through using the skills of observation and reflection the therapist can bring the person into the present. Jenny (AT) gave the example of observing her client smiling and reflecting that back to the person by saying "so you are smiling." In doing so she was acknowledging the person and grounding him in the present. Table twenty-two illustrates the five key areas of *person-centred* therapy practice that were employed by the arts therapists.

Table 22 - Statements illustrating person-centred ways of working	
• I am very much led by the client (Stella, DMT). • I mostly don't suggest things (Michael, MT). • I would ask the group what they wanted to do (Freya, DMT). • Not everybody chooses to make art work (Jenny, AT). • I try and put myself in their shoes (Pamela, AT).	Person-led
• There is no right and wrong (Ray, DT). • Whatever he/she wants to do and to feel is ok (Pamela, AT). • My role is me being the listener (Claire, MT). • Making eye contact and using touch (Kate, DMT). • My role is helping people if they need my help not just letting them sit (Jenny, AT). • I am encouraging the client to share their life story (Beatrice, DT). • The message I give is that what they say and what they do is important, valuing that (Pamela, AT).	Validating
• I give people quite a bit of reassurance (Pamela, AT). • I move closer to anxious clients (Alexander, AT).	Comforting
• You are sitting in a chair (Jenny, AT). • So you are smiling (Jenny, AT). • You have got your arms crossed (Pamela, AT).	Observing/ Reflecting
• It is just going with what works in the moment (Orla, MT). • It is very important to be very present and aware and to feed that back during the session (Sarah, DMT).	'Here and Now'

Sessions were framed around the needs of the client/group. In this sense the arts therapist would take his/her lead from the client and work with what he/she brought to the session. Linked to this approach is the notion of validating the client, taking the lead from the person, engaging him/her in a meaningful way that validates the person's experience. In terms of comfort the arts therapist provides support to the person by paying close attention to the 'here and now' needs of the person, for example, recognising when the client requires reassurance.

Psychodynamic theoreticians and theories

Psychodynamic theories were employed by the arts therapists to understand the dynamics of the therapeutic relationship. Rebecca (MT) observes, "…the relationship is fundamental. It isn't always the music first". Psychodynamic

theories are influenced by many different theoreticians among those mentioned by the arts therapists were Bowlby (1997), Winnicott (1965), Jung (1978), Erikson (1963), Klein (1963) and Fairbairn (1994), Bion (1961), Foulkes (1964) and Waller (2002).

Bowlby

In terms of the relationship, the therapists participating in the study were most influenced by Bowlby's (1997) work on attachment and loss. Bowlby's (1997) work gave therapists a frame for understanding relational attachments and what happens when those are lost. Helen (AT) related in chapter seven about the loss of relational (and societal) attachment her client experienced during the progression of the disease. Helen (AT) commented that "*it was very difficult*" to relate to her own feelings about the type of attachment she had with her client. The woman was so distressed during the session that Helen (AT) would reach out to her by massaging her hand or if her client could not tolerate the therapy room then they would spend time just walking round the building. It was clear from the interview that Helen (AT) felt very unsure about the type of relational attachment she had had with her client. Commenting on massaging her client's hand she added: "*I don't know what they would think about this in the art therapy world."* Helen (AT) had found it difficult to understand her relationship with her client within the context of the 'traditional' client-therapist relationship she had learnt about on her training course. She later came to understand through discussion with her supervisor her role as a witness, witnessing and supporting her client through her distress.

Jung and Erikson

Thomas (AT) spoke about the relevance of Jung's (1978) concept of *individuation* (the ability to accept or reject, in midlife, the polarities that exist with us and to come to terms with (or not) the life that has been led). Thomas reflected that AT offered his client the opportunity for individuation:

> "Jung's idea of individuation seemed to be very relevant because of the age group and the images. The notion of opposites tearing off the male and female and coming together is clearly visible in images (and the relationship). The client who was the widowed mother was trying to pair

> myself up with the manager who was a woman. On one level she was looking after her family, looking after her son, and on another level I think she was beginning to integrate her previous material" (Thomas, AT).

Bernard (DT) was influenced by Erikson's (1963) stage theories. Like Jung's (1978) notion of individuation and Erikson's (1963) final stage of the life cycle, the person needs to accept the conflicting states of Integrity versus Despair for successful integration to take place.

Bion, Foulkes and Waller

Romy (AT) and Alexander (AT) were influenced by group theorists such as Bion (1961) and Waller (2002). Romy (AT) commented that although all these theoreticians developed their thinking for more mainstream psychiatric work, the theories are useful for all groups. She said that a group of older people who have dementia go through the same group processes as any other group. She used Waller's (2002) *Group Interactive Model* in her work. She spoke of the model giving her a theoretical frame for understanding how people are with each other in the group, during the group and how the group process the session. Alexander (AT) cited the influence of Bion's (1961) work on containment, Foulkes' (1964) group matrix, as well as Nitsun's 'anti-group' on his work.

Klein and Fairbairn

Other key psychodynamic influences cited by the arts therapists were those of Klein (1963) and Fairbairn (1994). Thomas (AT) spoke of working with one client who suffered from depression when he was younger; this had resulted in him being separated from his siblings during his school years. He was a clever child and had been sent to a different school. He had not enjoyed school. The man came to each art therapy session but only drew twice, preferring to talk during the sessions of his "bad schooling" and feelings of sibling rivalry. Thomas (AT) felt able to contextualise the issues that were arising for his client (outside the session) within the theories of Klein (1963) and Fairbairn (1994). He felt that Klein's (1963) thoughts on the 'depressive position' and sibling relationship and Fairnbairn's (1994) work on the '*internal saboteur'* helped him to understand how his client's past experiences had shaped his present situation and how his client was

approaching the therapeutic relationship, for example his desire to talk more than to create an image.

Winnicott

Many arts therapists spoke of the influence of Winnicott's (1965) theories. His writing on *play*, *the transitional object* and the *holding environment* were cited by arts therapists as being of particular importance. Sally (AT) said:

> "Older people can be playful as well. I think there is always a child in every adult" (Sally, AT).

The arts therapists spoke of the importance of creative play. Winnicott's (1965) squiggle game was used by the art therapists to get clients starting to draw. Many sessions were spent in creative play. It was a good way in which clients could overcome their participation anxieties and re-learn some of their forgotten skills. Stella (DMT) spoke about her clients playing ball games in the session and how this could awaken the person's throwing and catching movements. One interesting reflection made by Sally (AT) and Janice (DMT) was with regards to the perceptions of older adults and *play*. Sally (AT) spoke about a heated debate she had with a member of staff when she mentioned the importance of adult play. The member of staff felt that Sally (AT) was belittling her clients by talking about *playin*g with them. Similarly, Janice (DMT) spoke about the "stick" she got from her group, who thought the sessions were childish. They felt that throwing a ball and using a parachute was child's play. Interestingly, when she offered a different type of session her group got very upset and wanted to return to the ball throwing and using the parachute.

Winnicott's (1965) concept of the *transitional object* was important to the arts therapists as it helped them to understand the triadic dynamic of the client, therapist and art form relationship. The transitional object in Winnicottian terms is the triadic element within the dyadic mother-infant relationship. It takes the form of the blanket or comforter used by the baby during the mother's absence. Translated into arts therapy work this meant that the image, piece of music and movement, role-play was viewed as a third element in the client-therapist relationship. The other key Winnicottian influence was that of the *holding environment*, the concept of the

mother (therapist) providing a safe and consistent environment for the child (client) in order to develop a trusting and supportive relationship.

> "What I feel is important is constancy, same time, same place, myself and the nursing assistant here every week. Having this space helps the clients to identify with it - they recognise the room, the constancy of it, a place away from the ward" (Orla, MT).

Kim (AT) identified herself as one of the only constant people in her clients' lives.

> "I see me as a person that is constant, probably the only consistency that they have, especially in the later stages of dementia" (Kim, AT).

The role of the arts therapist as *constant* in the lives of their clients was something that was keenly felt by the arts therapists. I noticed when I revisited the interviews that even when arts therapists claimed no direct psychodynamic influence on their practice they still spoke of the concepts of the *holding environment, transitional space* and the more Freudian concepts of *transference and counter-transference dynamic*.

Transference and countertransference

Kim (AT) reflected on her clients' perception of her as their granddaughter. Her clients would give her advice, share 'pearls of wisdom'. In this way their life was coming full circle and they were passing their knowledge on to a new generation. Transference and counter-transference was the most discussed psychodynamic strand. Traditional verbal explorations of the transference and counter-transference dynamic were not undertaken in session but were discussed outside session in supervision.

> "The psychodynamic work that goes on can often be in my supervision. My clients are largely non-verbal so I am reflecting on the work outside the session. Occasionally, I have felt that *in the moment* I could reflect back to them in a psychodynamic way but that has been a challenge because I am not so sure that *in the moment* in a group it is always helpful to work in a more reflective way, but then musically that is what I try and do - is to reflect. For example, if someone is sitting head down I might reflect back the mood I am feeling from the transference and counter-transference. I think in those terms I do it because with this client group the verbal is difficult so I use the music to build a relationship" (Orla, MT).

Sarah (DMT) noted that some interpretations, when possible, were made on what was happening in the session but that there was lack of detailed exploration of the transference dynamic. This was the same for all the arts therapists. Susan (DT) discussed her reason for not making implicit to the clients in session the transference and counter-transference dynamic.

> "I would pay attention to the transference and counter-transference but not make it explicit to the client group, but it would inform me. I have found this important because with clients with dementia their egos are disintegrating. They are at an unintegrated stage so a lot of their communication is unconscious, (much of the communication in DT is done through projection). I do use that to inform myself about what is maybe being communicated in the session" (Susan, DT).

Heather (AT) used psychodynamic concepts to understand her own processes, to reflect on her ability to tolerate and stay with her client during the session. She spoke about the importance of being able to re-evaluate what had been happening in a session with her supervisor. She felt this self-processing might be something that other non-therapeutically trained staff could benefit from learning.

Psychodynamic ways of working with clients who have dementia

An issue that was preoccupying some of the art therapists was how psychodynamic theories fitted with their dementia work. Some of the arts therapists were struggling to adapt principles used in the general psychotherapy field. This often led to contradictory statements being made by the arts therapists. Pamela's (AT) statement below illustrates this point.

> "Psychodynamic work with people with dementia? Forget it! Undoubtedly there is a lot of transference and counter-transference concerning mother and daughter figures" (Pamela, AT).

Pamela's (AT) statement was not an isolated one. Sarah (DMT), Pamela (AT), Jenny (AT) and Jasmin (AT) all commented on the rigidity of psychodynamic thinking. Sarah (DMT), who was more influenced by psychodynamic thinking than Pamela (AT), highlighted the way she adapted psychodynamic principles in practice.

> "I find a purely psychodynamic way of working (with this client group) is too rigid. You can only truly work in the psychodynamic way when you are working with clients who could be termed "normal neurotics." So when I say

psychodynamic I am thinking about transference and counter-transference and what concerns me in the session is the relationship. Bowlby's work on attachment was a key influence" (Sarah, DMT).

Table twenty-three illustrates the arts therapists' psychodynamic ways of working.

Table 23 – Statements illustrating Psychodynamic Ways of Working	
• I would refer to the other relationships that are going in their lives (Steven, DT). • I told Mary that Betty had died (Steven, DT). • The individual I see is very much based on the relationship - it is different to group work (Sarah, DMT).	The relationship
• What was important was the continuity of my presence (Sarah, DMT). • I see myself as a person that is constant, probably the only constant they have, especially in the later stages of dementia (Kim, AT). • One of the most valuable things was the regular, reliable constancy of having the group at the same time (Romy, AT) • They do recognise this room. The constancy, a place away from the ward (where they can have a different kind of interaction) (Orla, MT).	Holding environment
• I would reflect back and talk (Susan, DT). • I would interpret what the story might be (Steven, DT).	Reflecting/interpreting
• I reflect on how they see me in the relationship (Michael, MT). • I think about the transference and counter-transference issue very much. Working with older people you can be seen as the daughter - that kind of role reversal goes on so much (Kim, AT).	Transference/ counter-transference
• Often clients are trying to put to rest their life (Bernard, DT). • You know, to a certain degree it is very helpful to go back, for clients to remember things of the past. Of course with elderly populations a lot of material that comes up in sessions is to do with the past but I think it is important to make the link as to how does the past affect you now (Sarah, DMT).	Past issues
• The whole essence of playfulness is important (Ben, MT). • Older people can be very playful (Sally, AT).	Play
• The transitional space because it is an important meeting place of past, present and future for the clients (Susan, DT).	Transitional space

Disciplinary distinctions in relation to psychotherapeutic theories

Despite the strong overall influence of the person-centred approach there were distinctions between the disciplines as to *how* influenced they were by the approach. For example, all the DMT participants except Sarah identified themselves in psychotherapeutic terms as purely person-centred.

> "Our model here is very much humanistic, very person-centred, very Rogerian" (Freya, DMT).

Interestingly, the DT participants identified themselves more tacitly as being person-centred than the dance movement therapists. For example, the dance movement therapists used the actual term '*person-centred'* to identify their psychotherapeutic position, whereas the DT participants tended to not use the term directly but rather to speak in more general terms about "focusing on the individual" and "nurturing the person" (Beatrice, DT). The AT participants, like those from DT (apart from Jenny) did not use the actual term *person-centred* to describe their theoretical orientation. However, analysis of the methods they use revealed that they *were* working in person-centred ways (Table 22) with their clients, while thinking about the therapeutic relationship in psychodynamic terms. Jenny (AT) was the exception to the rule:

> "I actually went towards the person-centred approach. That's how I work" (Jenny, AT).

Jenny (AT) refers to moving toward the person-centred approach and away from the psychodynamic principle that underpinned her training. I found that Pamela (AT) and Jasmin (AT) shared Jenny's (AT) questioning of the relevance of psychodynamic thinking with this client group and had begun to incorporate other newer theories (e.g. coma therapy) into their practice. However, the general AT trend was an integration of both the person-centred (tacitly rather than overtly acknowledged) and psychodynamic theories (overtly acknowledged) into their work. The AT participants also appeared to be influenced more by psychotherapeutic than artistic theories. This picture was reversed for the majority of MT, DMT and DT participants, who were generally more influenced by their respective artistic traditions rather than psychotherapeutic theories. The exceptions to this were Ben

(MT), Orla (MT), Rebecca (MT), Susan (DT), Beatrice (DT) and Sarah (DMT) who were equally influenced by psychotherapeutic theories and by their respective artistic theories. They discussed in-session work in terms of person-centred and artistic theories but, post session, like the art therapists, reflected on the relationship within a psychodynamic context.

The theoretical position of the arts therapists was quite fragmented in the sense that the arts therapists were borrowing from existing mainstream theoretical models and attempting to apply these to this very specific client group. For example, I had a surge of feeling during the analysis that the MT, DT and DMT psychotherapeutic position was often a bit vague. Apart from the thoughts of Orla (MT), Rebecca (MT), Ben (MT), Susan (DT), Beatrice (DT) and Sarah (DMT) the remaining therapists from these disciplines tended to speak of their psychotherapeutic influence in general terms, often listing theoreticians names and psychodynamic terms rather than explaining in depth how they influenced their practice. The first reason for this was as mentioned earlier, MT, DMT and DT participants were more influenced by their respective artistic theories than the AT participants. Secondly, it is very difficult to pin an existing theory onto a very dynamic client group.

Artistic and other discipline theoreticians and theories

Each discipline was influenced to a greater or lesser extent by a mix of artistic and other theories. I use the term “other discipline” to encompass the diverse range of psychological, physiological and neurobiological theories that often influenced the development of artistic theories.

AT artistic and other discipline theoreticians and theories

Waller, Byers and Moon

Thomas (AT), Romy (AT), Alexander (AT) and Kim (AT) all mentioned the importance of Waller’s (2002) research and writing in awakening the AT field to the potential of working with older people who have dementia. Kim (AT) was influenced by Byers’ (1995, 1998) writing on using everyday objects in the AT session as a way of locating the session in the familiar for the client. Kim (AT) spoke about

laying out everyday objects on the art table. Her clients responded to these by touching them and treating them like sculptures.

Kim (AT) was also influenced by the writing of Hyland Moon (2005) on the use of the therapy space in art therapy. Hyland Moon (2005) suggested that the focus should be on the art within the space rather than always on the relational dynamics. Hyland Moon (2005) believes that the AT profession has been too consumed by theoretical influences from outside the discipline and that there is a need to return to an artistic core. Hyland Moon's (2005) thoughts appealed to Kim (AT) particularly with regard to working with people who have dementia because many sessions were just about the art making.

> "I have found it quite hard to get to grips with the psychodynamic process and art therapy. I am the kind of person that thinks that the art work is so important, more and more so the longer I work in art therapy" (Kim, AT).

Kim (AT) was one of the participants who had worked the longest with this client group and as such it was interesting for me to hear her speak about the importance of the art work.

Coma Therapy

Pamela (AT) spoke of the influence of *Coma Therapy* on her AT work with her clients. She described coma therapy's (1988) roots as a "mish mash of different approaches" ranging from process orientated psychology to Taoist thinking and Jungian influence. In coma therapy the therapist is working with the person in a coma or in the later stages of a very progressive disease, such as dementia. The therapist works in a very minimal way. For example, with the person's breathing, twitches or jerks - any movement the person may make. The work involves a lot of mirroring work, empathising with the person and giving the person continuous positive verbal feedback. In practice Pamela (AT) gave the example of working with a client who wanted to stretch his arm upwards but was prevented from doing so because of a lack of dexterity. Pamela (AT) would support the person's arm and help him to stretch it by encouraging him to extend his arm as far as possible and beyond. Pamela (AT) spoke of working intuitively, using resistance to encourage the person to push against her hand. Coma therapy's (1988) application to AT is

using the person's often overlooked minimal movements to build a repertoire of other movements which in AT terms could help the person focus and participate in session (e.g. sort through textured materials).

MT artistic and other discipline theoreticians and theories

Aldridge

Ben (MT) was the music therapist who discussed most the artistic and other discipline theoretical influences. He was influenced by Aldridge's (2000) MT writing, in particular his thoughts on dementia as a "dialogic–degenerative disease" in which the emphasis is placed on society to learn the correct context for communication (2000) with the person who has dementia. Ben (MT) was also influenced by Aldridge's (2000) thoughts on the time structure of the person with dementia and how structuring the person through music could enable the person to locate events and create a continuum. Ben (MT) was influenced by Aldridge's (2000) discussion of *now* for the person with dementia as a single moment not a series of moments. It is the role of the music therapist to help the person join the single moments into a meaningful series of moments that come together in a dialogue with others. In practice providing this connection of moments can be achieved through drumming. Ben (MT) spoke of this very basic form of music making as providing his clients with a rhythmical aspect that helped them to feel connected.

Csikszentmihalyi and Demasio

For Ben (MT) Mihaly Csikszentmihalyi's (1990) writing on *flow* was important. Csikszentmihalyi's (1990) notion that people are at their best when they are in a state of flow fitted with the rhythmical sequence of playing music and with Aldridge's (2000) time structure theory. Ben (MT) also spoke of the work of neuroscientist Antonio Demasio (2000) and his neurobiological work on how mind and body processes are interlinked at a deep level.

Trevarthen and Stern

The work of the behavioural psychologists Trevarthen (1979) and Stern (1974) was discussed by the music therapists (although Stern's work does influence the other arts therapies such as DMT) it was not mentioned in connection with their dementia and DMT work. The music therapists Louisa (MT), Ben (MT) and Rebecca (MT) spoke about the influence of Trevarthen (1979) and Stern's (1974) on their work in particular their writing *on mother-infant communication.*

> "For me it provides a very firm grounding for understanding how the music therapy might be working, almost like the music therapy relationship is functioning like a kind of surrogacy of the mother infant relationship"
>
> (Ben, MT).

Ben (MT), Louisa (MT) and Rebecca (MT) were interested in the way in which the mother attunes to her baby's sounds. In doing this the mother is initiating but also mismatching the sounds of her baby, thus allowing the baby to grow and develop awareness. This is framed within a context of mutuality and is at a level that both mother and baby can understand – a two-way process. In MT terms the therapist picks up on the pulse or rhythm made by the client and begins to respond. The therapist or client may begin to make subtle changes to the rhythm so there are moments of harmony and moments of disharmony. These moments are framed within the mutuality of the established relationship. Rebecca gives an example of how this might work during a session.

> "We tend to intersperse singing with playing because there are some people who respond well to one thing and not to another so in doing this no-one is left out for too long. They can find something to join in with as well as to retreat to if necessary" (Rebecca, MT).

Trevarthen (1979) and Stern's (1974) work fits with the notion of improvisation. As stated in the literature review this is a key concept in MT (discussed more fully in the section on directive and non-directive working)

DT artistic and other discipline theoreticians and theories

The dramatherapists' theoretical influences centred around artistic theories. Writers such as Jennings and Mitchell (1973) and concepts related to the story, play and metaphor were discussed.

Jennings and Mitchell

Beatrice (DT) spoke of the influence of Jennings and Mitchell's (1973) *theatre model* on her work.

> "(In the theatre model) the art forms of theatre and drama are viewed as healing aspects of the therapeutic intervention. The dramatic distance or aesthetic distance achieved by working with text, improvisation, mask or puppet enables the client to achieve new and insightful ways to view themselves and the world around them" (Beatrice, DT).

Beatrice (DT) and Heidi (DT) said that at the heart of the model is Jennings (1973) anthropological belief that we are born dramatised.

> "I firmly believe that we are all actually born already dramatised, from our pre-birth experiences with our mothers. I think that to allow that dramatisation to develop parallel to other forms of development is really important for mental health" (Heidi, DT).

Bernard (DT) and Steven (DT) explained the notion of dramatic distance to me. Bernard (DT) said that DT helped to reinforce a sense of self in the client because he/she was able to metaphorically move out or away from his/her present situation. Steven (DT) explained the concept as one in which the client works as far removed from his/her experience as possible; the paradox being that in so doing the person is actually brought closer to that experience. Using Beatrice's (DT) garden metaphor as an example, her client's feelings of grief and loss are spoken of in terms of seasons (at a distance), which enabled her client to come close to the issue (of loss) safely.

Heidi (DT), Susan (DT) and Bernard (DT) spoke about the influence of Jennings' (1998) Embodiment Protection Role (EBR) model (also mentioned in the assessment section) in working with people who have dementia. On discussing *embodiment*, Susan (DT) gave the example of a client embodying a feeling or

movement. One client wanted to fly around the room during a session, arms outstretched, like an aeroplane. They both spent the session flying around the room. In terms of *projection*, Steven (DT) views this as the person moving outside of their body. For example, Steven's client chose a character and named it "Fred." By doing this she was projecting herself onto someone outside herself. In terms of *role,* DT clients would often take on a role in a session. Bernard (DT) might use soap opera characters as a starting point for locating his clients in the familiar. One client took on the role of Bianca Jackson in *Eastenders*. The character the person chooses, the role the person perceives the character plays in the soap opera, can tell the dramatherapist and the group about the person's own story, how the person is feelings about things and what issues are preoccupying him/her.

Story and metaphor

In DT stories were used as *connectors* to connect the person to his/her imaginative world and also to bring the person into the "here and now". In terms of a theoretical model, Steven (DT) spoke of employing Mooli Lahad's (1992) *six-part story method* for clients in the earlier stages of dementia, with clients in the more advanced stages of dementia. Steven (DT) adapted the model in the following way:

> "I might actually do almost a six-part story but I would ask which character (toy figure) or object (jewellery, little basket, miniature houses) you are drawn to. The group might talk about what these objects remind them of. When I asked Mary, she said who she was drawn to. She picked up a figure and said, 'Well this is Fred', so I said, 'Well you tell me about Fred, and so it would became a story in which she incorporated some of the other characters. The other client was not able to talk but she picked up the objects and looked at them. She seemed happier to play a musical instrument and create a sound track to the story" (Steven, DT).

Steven (DT) felt the use of story was very much located within the realms of DT rather than what he termed reminiscence work. Ray (DT) agreed with this. They both felt that, although reminiscence work was present in DT, DT went beyond reminiscing because, for example, they used structured story telling models like the six-part story method. They were also interested in not just the reminiscence story but in how the telling of the story impacted on the person emotionally. Moreover, these past emotions could be brought into the present; the person would be helped to cope with their current situation.

Stories contain metaphors. Beatrice (DT) spoke of using stories, myths and rituals as containers for exploring metaphorically her clients' feelings. For example, with clients in the earlier stages of dementia who were experiencing loss and grief she might use a garden metaphor, using the changing seasons and plants to help the person speak of his/her feelings.

Play

The majority of DTs spoke of the significance of *play*. Their understanding of play appeared to me distinct from Winnicott's (1965) concept of play. Winnicott's (1965) name was not mentioned by the DTs. The DTs understanding of play seemed to come from a wider realm, a belief that play (like drama) was innately within us and not contextualised in a specific theory. Susan (DT) was the only DT to speak of using a specific therapeutic model for her use of play. She said that she had adopted a non–directive play therapy model in her work along the lines of the one developed by Axline play therapy model.

DMT artistic and other discipline theoreticians and theories

The dance movement therapists were influenced by artistic theories, in particular, movement theoreticians such as Laban (1975), Kestenberg (1999), Morris (2004) and aspects of Whitehouse, Chodorow and Adler's (1999) authentic movement.

Laban/Kestenberg Movement Profile

Sarah (DMT) spoke of the influence of the Kestenberg Movement Profile (KMP) (1999) which is an integration of psychodynamic and movement theories. Sarah (DMT) said that the model integrates Freudian drive and instinct theory and Klein's object relations theory with Laban's (1975) movement analysis theory. In essence, the model looks at the innate movement patterns that start in the womb and shape the core of who we are giving us a sense of being. In methodological terms, Sarah (DMT) said that she incorporates movement theory, so looking at shape, space, body and effort, within the context of the relational interactions.

> "In session I am thinking about the clients and where they are at. I use transference and counter-transference a lot. I look at how my body wants to respond to the movements (made by my clients). I also look at the movement metaphors, imagery and symbols that come up for myself and other people to see what they are communicating. Whatever they are communicating I will try to find a word to express that so it becomes verbalised and tangible" (Sarah, DMT).

Sarah (DMT) was the only DMT to speak of integrating psychodynamic and movement theory although in practice the technique of verbalising a movement was shared by the other DMT participants. The distinction to my mind between Sarah's (DMT) way of working and the other DMTs was that they tended not to think about the transference and counter-transference dynamic or about the historical (in terms of their client) context of their clients' movement patterns. Instead, they worked from a more 'present' standpoint, thinking about the movement patterns as they were presented within the session. All the DMTs, except for Laura (DMT), mentioned the significance of Rudolf Laban's (1975) Laban Movement Analysis. (LMA) work as a backdrop to their understanding of their clients' movements.

> "I do incorporate some of (Laban's) movement theory into the warm-up. I incorporate shape, space, as well as effort. You can actually use the sagittal, vertical and horizontal planes to help deepen somebody's movement repertoire, and by offering a very rich vocabulary in movement I feel that it helps to give some people access to some of the hidden parts of their body language" (Sarah, DMT).

Margaret Morris Movement

Laura (DMT) did not speak of the influence of Laban (1975) but rather of Margaret Morris Movement (MMM) (2004). Morris developed a structured movement technique which was used for example in breathing exercises. She trained as a physiotherapist so the mechanics of the body's movement repertoire were at the heart of her approach. In sessions Laura (DMT) said that she drew on Morris's (2004) technique to think about her body and how she moved, while at the same time drawing on her DMT training to think about the emotional state of her clients

Role of witness

Freya (DMT) talked of the influence of Authentic Movement (AM). The model was developed by Whitehouse, Chodorow and Adler (1999) and integrates "Jung's concept of active imagination and modern dance improvisation" (authenticmovement.org, 2008). It is used with clients who are able to process their conscious and unconscious responses to movement making. Freya (DMT) did not practice the model fully with her dementia clients but she did adopt the AM position of being a *witness* to her clients' movement-making.

> "The role of witness is a very valued one. I wouldn't use it overtly with people who have dementia so not layering on assumptions about the way a person sits or the expression on their face, because with dementia there can be a degree of stuckness. Facially they can become less mobile and that can send a signal which means that I respond in a particular way, but with my AM hat on I would stand back and say, hang on a minute, that signal might not be at all correct, inside there might be quite a serene person, or someone who is angry, or an incredibly happy person. Those are all very simple sorts of expression of what emotion the person might be experiencing, (but it is important) not to assume that the perceived emotion is the (client's) emotion" (Freya, DMT).

Interestingly, Freya (DMT) said that the reason why a model like AM is not used with cognitively impaired client groups (dementia, learning difficulties) is that this group of people move from a different point of awareness; their movements are spontaneous and are not choreographed like those of her cognitively functioning clients, who tend to choreograph a dance in their head.

Montagu

The notion of touch, while not directly an artistic theory in the sense of KMP or AM, is an important aspect of DMT work. Stella (DMT) and Freya (DMT) spoke in more general terms about the use of touch in DMT sessions; both therapists used touch to massage their clients' shoulders or to hold the person's hand. Kate (DMT) was influenced by the anthropologist Ashley Montagu's (1971, p.5) writing on *touch*. He considered touch to be "the authentic voice of feeling." He believed that touch stimulated the neuro-chemical pathways in the mind and body. Kate's (DMT) interest in touch originated from professional and personal observation of what she

termed the lack of touch for older people in residential care. Kate (DMT) had developed a series of reminiscence boxes for use in her DMT session.

> "Touch and bodies were quite tricky so that is when I decided I would use reminiscence boxes. I wanted a multi-sensory package. They were quite big boxes with handles on them. Inside there would be various objects all with completely different textures, shapes and smells, so it was a very multi-sensory experience, which meant that they could pass the object around and touch it. By the end of the session they were willing to do some movement work using a parachute or holding hands. I make a point of acknowledging goodbyes by holding people's hands" (Kate, DMT).

Kate (DMT) used the sensory touching of the reminiscence objects to stimulate her clients' touch/movement capacity.

Directive and non-directive working

The issue which most concerned the art and music therapists was the topic of *directive* versus *non-directive* working. The concept of non-directive work, as discussed in the literature review, has its roots in Rogers' (1953) person-centred approach, although it has been adopted by arts therapists as a quasi artistic theory. In *non-directive* work the arts therapist does not direct the client, instead preferring to let the client find his/her own way through the creative process. The belief being that the more the arts therapist intervenes, the more she brings of him/her self to the session, then the less the client learns to understand and value his/her own learning process. *Directive work* is the notion that the arts therapist guides or directs the client through a series of themed activities. The findings highlighted that when working with older people who have dementia the AT and MT participants felt challenged by the issue of directive and non-directive working. Thomas (AT) spoke of having to make a shift away from his "traditional" non-directive way of working in order to incorporate directive elements in the session.

> "(My way of working) has changed because I had to move from a non-directive to a more directive way of working. Initially the idea of Foulkes' matrix was prevalent, that tends to run through most of the work I do because the relationship with the therapist is usually secondary but that wasn't working (here). I thought if I keep (on working this way) I am possibly going to be perceived as remote which would remind them of too many bad previous experiences. So I had to move from that position" (Thomas, AT).

> "How did you manage the more directive work?" (Jane)

> "Initially they wanted to use things that were actually in the room, that characterised the first three or four sessions. I think it was a way of them locating their experiences in the familiar. They then went on to talk about things they had on their mind. I think they were getting more confident about bringing things into the sessions" (Thomas, AT).

In methodological terms, Thomas (AT) illustrates how his move from a non-directive to a directive approach enabled his clients to "locate their experiences in the familiar". He talked of not wanting to remind his client about his "bad schooling". Thomas (AT) had moved from a purely non-directive to a more directive approach. Heather (AT) had also done this. She gave the following reason why:

> "If I were just to put art materials on the table and wait to see what happens, then (my clients would also) just wait to see what happens. So they really need me to direct them on to a theme" (Heather, AT).

Heather (AT), Helen (AT) and Kim (AT) spoke about working only non-directively but when I analysed the interviews I found there were some interesting contradictions. Kim's (AT) statement illustrates this point.

> "I work pretty non-directively. I don't know because a lot of arts therapists working with older people work directively but out of choice I have never felt comfortable working with themes… But if people need some direction then I will aid them with that"(Kim, AT).

In MT there was a similar debate. Music therapists are trained in i*mprovisation*. Traditionally, in session free musical improvisation is client led. The music therapist and client relate to each other through the music. Hope (MT) states that it is about working with whatever the person brings to therapy;

> "We use improvisation and making music with whatever the clients are able to bring of themselves"(Hope, MT).

Hope's statement illustrates the typical MT non-directive way of working. The findings suggested, however, that the majority of music therapists had moved away from employing an improvisation only model of working with their dementia clients towards an approach that combined both directive and non-directive elements. This was a "hot topic" for the music therapists.

> "There were some therapists who would feel quite strongly that it is appropriate to use pre-composed music and some who feel that it is not appropriate. I would say that it depends on your client group. For example with my acutely ill clients unless they asked me I would not think to bring a pre-composed song or piece of music to the session but with people with dementia I think it is really relevant. So I use it but I don't use it exclusively, I think that it is part of the package" (Rebecca, MT).

Orla (MT) spoke of the importance of Darnley-Smith's (2002) writing on MT with older adults. Darnley-Smith (2002) advocates the use of both improvised and pre-composed songs in sessions with this client group:

> "Certain songs played such a big part in my clients' lives, perhaps more than for any other generation. I initially thought I should only be improvising but well… I found the chapter by Rachel Darnley-Smith helpful. In session we might use a pre-composed song and the session would move from that into improvisation. I see the place of free improvisation as springing out of pre-composed song. I have seen work in a session often a well known song might trigger memories, difficult memories such as loss, that clients will then talk about" (Orla, MT).

Rebecca (MT) shared Orla's thoughts about the value of pre-composed songs as a memory aid. She felt that with these songs reminiscence is more likely. Rebecca (MT) also used pre-composed songs but she talked about using these "fairly carefully". She liked to be guided by the client as to the song that was used in the session. If her clients were unable to guide her to a particular song then she would choose a traditional song. Michael (MT), like Rebecca (MT), also used pre-composed songs but he would only use songs that his client brought with him/her to the session. Louisa (MT) used both pre-composed songs and improvisation in her sessions. She, however, was concerned with the issue of transition from the more structured phase of the session to the more unstructured. Louisa (MT) spoke of some of her clients feeling disturbed by the transition.

Emma (MT), Hope (MT) and Claire (MT) were 'anti' the use of pre-composed song with this client group. Emma's (MT) sessions were primarily improvised but she did sometimes use structured songs. She took the decision several years earlier to stop using pre-composed songs with this client group because she felt they did not hold or respond to the moment.

Hope (MT) used only improvisation with her clients. She said that in Australia the feeling is that improvisation creates confusion for this client group and the preference is for pre-composed songs. In her experience she has found the opposite to be true, that in fact pre-composed rather than improvised song created the confusion. Claire (MT) spoke of having developed her work around what she termed "improvisatory" ways of working. She used ideas from group improvisation.

> "I make the suggestion that the group might like to play some of the time and not play at other times. Really I let it run and see what happens. My role throughout is one of facilitating the unfolding of the group's music and if I feel it is getting very stuck or limited either I might stop the playing and ask people to reflect on that. I believe they are capable of doing that. Alternatively, I might get a sense musically of what the potential is of what we are doing and where it might go and I pick up on that"(Claire, MT).

I noted following Claire's (MT) interview that the debate was hugely controversial for the art and music therapists. It seemed to challenge the core of their therapeutic training and tradition. For the DT and DMT participants the subject hardly registered a comment. Susan (DT) said that she had adopted a non-directive play therapy model in her work along the lines of the one developed by the non-direct approach advocated by Axline. In general, I got the sense that in DMT and DT therapists were more at ease with using directive and non-directive elements within a session.

Methods

Overview

In this section I describe the *methods* (including the props, tool and materials) the arts therapists use when working in session with their clients. The literature review indicated that there has been no clarification with regards to the terminology used to describe the different elements that frame the progression of a typical session. Odell-Miller (1995) wrote about the traditional three-stage structure of introduction, central activity and final part.

Introduction to the session

I found that, generally, there were two phases in the introduction of an arts therapy session. The first phase, the *check-in,* was shared by all the arts therapies while phase two, *the beginning of the creative process* was more discipline specific, although there were shared elements. In this second part of the session the arts therapist adopted a fairly *directive* approach.

Introduction (phase one)

In phase one, group members would come into the session and sit on chairs in a circle facing each other. Clients coming to AT would typically sit round a table, in MT clients might choose to sit beside a favourite instrument, but within the circle. The therapist would welcome everyone individually to the group, going round each group member saying, for example, *"Hello Bill, how are you?"* With group members who were verbally unable to respond Pamela (AT) said that she would make an observational comment like, *"Betty, you are wearing blue today*", so that the group could connect with Betty. One-to-one sessions would typically start with the client and therapist sitting side by side. Sometimes the therapist might sit across from the person but this depended on the person's preference as direct face-to-face contact could in some cases be quite threatening unless initiated by the person. Clients with more verbal skills might use this time to speak of an issue that was concerning the person, *"I am not sure what is happening to me."* In a group situation, this opening statement could then lead to other group members identifying with the issue raised and to some discussion around the issue. Typically, as clients moved through the disease their verbal comments might be more non-directive and more reminiscence in nature, for example, *"When I was a seamstress I made a blue dress for the lady down the road."* Such comments might lead the group into a discussion about their working life. With non-verbal clients the therapist would take her cue from the person's body movements, facial gestures or any non-verbal forms of communication to determine how the person was that day. Laura (DMT) liked to sit with her individual clients and hold his/her hand. In doing so Laura (DMT) was able to hear the person's breathing, to find out if they were feeling stressed or relaxed, to offer the person comfort if needed.

Introduction (phase two)

AT

The early part of an AT session was often directed, unless the group/client was sufficiently able to orientate themselves. Kim (AT) and Heather (AT) liked to bring the images/artefacts from the previous week to help contextualise the work for their clients. Heather (AT) spent the early part of her sessions helping her clients to identify different paint colours, squeezing paint from the bottles and choosing a palette of colours.

Directed exercises were often used. Kim (AT) and Alexander (AT) spoke of using Winnicott's, (1965) Squiggle Drawing and a Conversation on Paper. In the Squiggle Drawing the therapist and client or the whole group would work together on creating a quick free-form drawing. A 'Conversation on Paper' literally is a conversation between client and therapist on paper – an extension of the Squiggle Drawing. With Jasmin's (AT) group with early stage dementia, she used a word game. She asked her clients to pick a word and she then asked them three questions about the word: "What shape does it have?" "What colour does it have?" and "How does it feel?" and based on that Jasmin (AT) and her group would link the answers to the art materials that were going to be used that day, for example, the colour that was mentioned was the colour that first went on the blank sheet of paper. Thomas's (AT) sessions, with his early stage clients, were shaped by his clients' childhood memories. These memories provided the backdrop for the images.

Pamela (AT) liked to do more of a physical warm-up with her group of nursing home residents. The group would hit a balloon around the room. Pamela (AT) commented that it was a great way of engaging with people and helping them to build up a relationship with each other because the reflex action of the balloon coming towards the person made the person automatically interact. Pamela (AT) also spoke of using hats to engage the group. She said that she got the idea from a dramatherapist. She invited the group to try on hats.

MT

Following the initial verbal check-in, the MT sessions often began with a song. Louisa (MT) talked about singing a “hello song” with her group. Part of the singing of the song could include passing round a musical instrument on which each member of the group played a note and then passed it on to the person sitting next to him/her. The group might then go and choose (if they had not already done this when they first arrived) the instrument that they wanted to play during the session. An ongoing part of the MT session was re-acquainting clients with the instruments. Just as the art therapist might show the person how to use the art materials again, so the music therapist might show a client how to play a particular instrument again. In sessions the emphasis was very much on the person using the instrument as he/she wanted. For example, a client might use the surface of a guitar to bang a beat; but for some clients it was important to be shown how to play the instrument correctly and to begin by playing a piece of familiar music. Engaging the person too soon in an improvised piece of music could leave him/her feeling confused by the process.

Claire’s (MT) group didn’t start with a song but instead chose to do drumming. She said that the rhythmical beat of the drum was a good way of connecting group members. The basic beat acted as the connector and as the group grew in confidence they could experiment with the beat. Claire (MT) did not usually suggest things to the group but instead took her lead from them.

In Louisa’s (MT) session the group beat a large ghetto drum (the drum had different tonal qualities). One client liked to pace the room rubbing his hands together during the session. Louisa (MT) used the rubbing sound made by her client to form the base beat of the drum, this way engaging him in the session. Orla’s (MT) client also liked to pace the room during sessions. She spoke of having quite split and disconnected sessions with one client wandering around in the room while the remaining clients sat in a circle and played their instruments. She spent time finding a musical connector; most recently this was her violin. She played the violin to the group.

DMT

Kate (DMT), Laura (DMT), Freya (DMT) and Janice (DMT) liked to start the session with some music playing during the *check-in*. They used music throughout the session. Sarah (DMT) preferred not to use music in her sessions. Grace (DMT) liked to do a structured warm-up with her group.

> "I am looking at body parts, from the individual body part to moving body parts together and trying to integrate the whole. Some of the group are really able to stand while others are not and they will do the movements sitting in their chairs" (Grace, DMT).

Kate (DMT), Laura (DMT), Freya (DMT), Janice (DMT) and Sarah (DMT) did a less physical warm-up. Instead they worked on coordination skills.

> "I usually introduce a ball. It is good for coordination skills. As soon as you introduce the ball you introduce direct contact, it is a focus that people can follow. It is an object, a visual image and there is the motion of throwing and catching. I am surprised to see how easily people are able to catch the ball" (Sarah, DMT).

Sarah (DMT) began by throwing the ball to John. As she threw the ball she would say, "Here John" and then John using the same ritual would throw the ball to Margaret. This could be built upon. For example, in one of the open group sessions the group might describe a feeling as they threw the ball (happy, sad, etc…). After the ball exercise Janice's (DMT) group would move on to using bamboo sticks with feathers on them. The group would whack a balloon from stick to stick, passing it around the room.

Kate's (DMT) sessions were slightly different from those of her colleagues. Post *check-in* her group chose a theme and began exploring the objects related to the theme in the reminiscence box she had created. Kate (DMT) did adapt the sessions depending on the energy levels of her clients. For example, she might do more ball and prop work if her clients need to be energised.

DT

As part of Bernard's (DT) *check-in* with his early stage dementia group he brought "a friend" of the group, a mascot figure (a soft toy) that was passed round the group. Group members would talk to the mascot (and the group) about how they were feeling that day. Bernard (DT) also used other "continuing rituals" with the group:

> "I have a plastic cart, a big thing that they can hold on to and we do a round of that and then I have got a big brass car hooter, it makes a lovely raspberry sound. We will do a round of what I call 'naff' things which is about anything that has been a bit of a drag" (Bernard, DT).

At the beginning and end of Steven's (DT) sessions he would create a threshold by banging a cymbal to mark the start and end of the session. During the introductory phase Steven (DT) liked to include a name game to help orientate the group. He would play his guitar and the group would sing together. Steven (DT) and Bernard (DT) liked to encourage their respective groups to move during this initial phase. Bernard (DT) called it "dancing in chairs." He played music and gave the group scarves to get them moving. He felt that the selecting and rejecting of the scarves was a good way of promoting choice.

> "The conversation of choice is very important and how we deal with that because it is about empowerment of choice. I have seen quite frail elderly people work the scarves and enjoy the scarves and interact with other people's scarves. They enjoy the music and can be very creative. It tends to create a bit more energy in the group" (Bernard, DT).

Susan (DT) liked to offer her one-to-one clients a selection of natural objects (flowers, fluids and earth as well as dough/clay and a sand tray). If her clients did not want to use an object then she worked with the person's movements or sounds.

Bernard (DT), Steven (DT), Susan (DT) and Beatrice (DT) stated that what happens at the beginning of a session depended on their client(s) mood and capability.

> "You have to be sensitive to the patients. I am working in an acute ward at the moment and warm-ups aren't relevant. I mean I can be working with a person who is very distressed and we need to speak about their distress, so

> the talk may be the warm-up and we may not get round to doing a main activity. It really depends on the person" (Steven, DT).

Steven's (DT) comments about being '"sensitive to the patient" were shared by all the arts therapists.

Central part of the session

The central part of the session was to use Claire's (MT) word "*improvisatory"*. The arts therapist and client(s) would work together in ways that were often unique to the particular circumstances of their relationship. Directive and non-directive elements were used but the degree to which these shaped the session was dependent on the needs, preferences and ability of the client and therapist.

AT

The central part of Kim's (AT) open group session on the ward was not structured. Her clients would come and use the art materials independently. Kim (AT) would go around each individual and work with him/her. Her clients tended not to speak (even if verbal skills remained) about the work to the group. I asked Kim (AT) the reason for this and she said that her clients were in a state of flux; a person might only attend one or two sessions or might come for six months depending on their length of stay in hospital. Sometimes they just wanted a place where they would just 'be', a place where no-one asked them lots of questions. When I visited the setting I saw that the work was undertaken on the ward. At the end of the row of beds was a series of tables that were used for both dinning and leisure activities. I understood the impact the environment must have had on the sessions. Kim's (AT) other work was in the privacy of the hospital therapy centre. These sessions were more boundaried, Kim (AT) saw the same clients over a longer period of time (same time, same place each week). These sessions were more interactive as there was the opportunity to build up the relationship with her clients over a longer period. Her clients liked to use the sand tray to make images in the sand or place reminiscence objects in it and sometimes they linked them back to particular memories. Other clients might choose to use her 'picture box' full of cards with pictures on them. They could sort through them for inspiration and find something that interested them. This then might be used as a starting point for an image,

during the creation of which the person might tell Kim (AT) the story behind the image and together they would witness the unfolding story.

The aim of Heather's (AT) session was to break down the isolation experienced by her clients on the assessment ward and continuing care wards where she worked. For Heather (AT) this meant not letting her client(s) sit unoccupied in the session but engaging them in art making which was located in their familiar experiences. For example, with her female clients they often chose to knit and sew during the session, in so doing they were propelled back to more familiar times, times when they were active agents in their lives. In a similar way, Heather's (AT) male clients enjoyed the process of making their images, building objects speaking about their 'active self'.

Helen (AT) thought that one of her clients was looking to gain control over his feelings of disintegration. He spent his sessions using a ruler and drawing lines. He then liked to fill in the lines with colour. He liked to talk while he drew.

> "Rarely the work appeared related to what he talked about. Though once when he was talking about violent conflict and religious divide he commented that he saw his work contained the green Celtic and the blue for Protestantism. He had painted these two colours as green and blue arrows pointing at each other" (Helen, AT).

Helen (AT) said that her client talked, sometimes with great clarity, about his past experiences. Thomas's (AT) clients, similarly, liked to draw as they reminisced about their past. They initially used everyday objects (in the room) as inspiration for their images. As time progressed they became less reliant on the objects, instead they took inspiration from their own thoughts and feelings. For example, in one session a client talked of cowboy movies and boxing. He drew an image of a cowboy. Thomas (AT) felt that his client was exploring issues of resistance in the session. He said that his client presented himself as being very in touch with his feminine side but his drawing was depicting this other side of him.

Pamela (AT) commented that AT sessions were more about the relationship than the art materials. In the middle part of her sessions she often took her cue from the "meanderings" of her clients, from the way the person held the art materials.

> "I would have something in mind that might not always be with the art materials. I might go round and ask people what they wanted to do. If I have a group where people were unable to express their preferences I would put some sensory objects on the table and we would work with those" (Pamela, AT).

She might mirror back what the person was doing. One example was her work with a client with advanced dementia who had an oral fixation, he liked to constantly put things edible or not in his mouth. Instead of telling the person not to do this she would work with that and try and find things that the person could put in his mouth, for example a bowl of jelly. It could be played with and eaten, the texture and colour of the jelly could be explored.

Jenny (AT) spoke of sessions where art materials might not be used. She said that some group sessions were spent recording and writing down her clients' memories. Other sessions were spent working on group images. These were passed around and shared in the group, with each person given the opportunity to make a mark on the image. Other sessions were spent with the group members working on individual images. Jenny (AT) explained that the group moved through different phases, not just because of the progressive nature of the disease, but because the natural life of the group was in a constant flux as people's interests changed, as they developed new skills and as they began to explore their memories.

MT

Louisa (MT), Orla (MT), Michael (MT) and Rebecca's (MT) sessions would have a mix of pre-composed and improvised music making. Orla (MT) spoke of her work with clients from the continuing care wards. She said that after the initial song at the beginning of the session she would wait to see what happened. For example, a group member might pick up an instrument and start singing or talking. Orla (MT) might use her violin to respond to the person's playing, singing or talking. While responding to one person she observed how other members of the group responded to the music, to the melody, or to the sound of the instrument. In this way Orla (MT) built up a repertoire of songs and sounds that she knew her clients would respond to. Orla (MT) integrated improvisation with pre-composed songs in her session. Rebecca (MT) similarly liked to use traditional folk songs in her session with her clients experiencing early stage dementia, songs that were familiar to

them. In her group session the group would play one or two songs together, then Rebecca (MT) would improvise one to one with each member of the group. The group might then play again together. Rebecca's (MT) group liked to intersperse playing with singing so that there was an integration of different elements. Rebecca's (MT) one-to-one work had been with clients with much earlier stage dementia. She observed that clients experiencing this stage of the illness were much more able to tell her what they wanted to do in a session. She spoke of her work with one client:

> "For one lady it was very much connected with memory. She was grieving for her brother who had died as a young man and remembering that he had played the violin and what he had played on the violin. Sharing that and finding the music seemed to connect with her" (Rebecca, MT).

I asked Rebecca (MT) what she thought the trigger had been for her client's remembering of her brother. Rebecca (MT) said that it could have been the improvised music that they played together, or the fact that she was surrounded by musical instruments. Rebecca (MT) felt that some unresolved issue had remained between brother and sister at the time of his death and this was what her client was bringing to therapy.

DMT

In DMT there was less of a distinction between phase two of the beginning of the session and the central part of the session. The central part continued to incorporate a series of different activities designed to re-connect the person's movement memory. These had a structured frame but within this frame the clients could improvise. Freya (DMT) gave the example of working with her group; the group used a large piece of stitched elastic to form a circle. Each member of the circled group would hold the elastic and the group would begin to experiment with it.

> "We experiment with what we can do with it. We take it across the space and loop it so it creates a spider's web. The clients that can walk, go across and balance the web, others sit and laugh. It might prompt a memory of cat's cradle" (Freya, DMT).

Freya (DMT) spoke about how the movement work often stimulated her clients' memories of past songs and stories. She talked about working with a group where

one of the clients had been a landgirl during the Second World War. Freya (DMT) asked her to show her what a landgirl did and her client began to mime digging and then started to sing an old Andrews Sisters song. Freya (DMT) did not know the song but the rest of the group did and they began to sing. In Sarah's (DMT) session her client's reminiscences were expressed in movement form. Sarah (DMT) would ask the person to describe how he/she felt about re-engaging with that movement. She might also offer her interpretation of how she perceived her client during the movement.

> "I mean, for example, in the session today there were certain strands that became very clear to me which were about freedom, wanting to get out of this place, isolation, not wanting to be alone. So there is this dilemma of wanting to move forward, wanting to put the past behind them but being unable to separate the past from the present, which is obviously a recurrent theme in dementia" (Sarah, DMT).

Sarah (DMT) in the above statement gives her thoughts on the whole session. When engaging with her clients she would not necessarily go into such a full interpretation but might just use the keys phrases such as, "I thought your movement was about freedom." Her client was then free to take on board her interpretation or not. Sarah (DMT) was interested in working with the conscious and unconscious movement metaphors of her early stage clients.

Dance movement therapists might offer a verbal interpretation of an individual's movement for that person/group to engage with. If the individual/group chose not to engage with the therapist's interpretation, then they might want to respond in different ways. The response of the group to the therapist's interpretation very much depends on the group. For example, Janice (DMT) worked in the same setting with two groups in different stages of dementia. One group had clients with less advanced dementia who were very vocal. She commented that they were not responsive to improvising a movement. Instead the group preferred to stay with more activity-based tasks such as using the parachute. The group would stand round the parachute and wave it up and down. They liked to laugh and have fun and chat about what they were doing. With the other group, Janice (DMT), like Laura (DMT), worked in a more rhythmical way. This might involve listening and moving to music or using props such as a drum to tap out a rhythm and to share the rhythm with others.

> "Many people still have dance skills existing even as rhythm. If people aren't physically able to dance there is still that sense of rhythmic connection and sharing a rhythm that is a very powerful way of being together" (Laura, DMT).

Grace (DMT) said that she welcomed clients to the space just to listen to the music and join the conversation if they wished. There was no requirement for the person to take part - being there and sharing the space was enough for some clients. Grace's (DMT) words were echoed by all the arts therapists. For example, Laura (DMT) might sit and make circular movements with her finger in the palm of her client's hand. This would begin the process of engaging the person in some form of movement and in the case of a stressed client might encourage the person to breathe in a more relaxed way, as the person's body tunes in to the circular movements.

DT

In DT, Beatrice, Steven and Susan spoke about the focus of these sessions as helping their clients to maintain engagement with others, to remain a *social being,* often in a very isolated world. Beatrice (DT) spoke of sessions spent in the residential home where group members would visit the room of another group member. Her clients lived in the same unit yet often knew nothing of each other's lives. With her individual clients she talked about working with them to write up their favourite story. The stories were placed on the walls of the home for everybody to read. This became an important connection for staff and relatives who in turn began to tell their own stories. The story became a focus for the unit.

Bernard's (DT) group liked to integrate talking with some form of symbolic interaction. The symbolic interaction involved using reminiscence objects (rolling pins, mincers and bells). Bernard (DT) would prompt the group by asking, "Do you remember the recipe?" The person with the rolling pin might mime the action of making an apple pie and the group would begin to discuss their memories of baking.

In working with clients with more advanced dementia the dramatherapists used less metaphorical story work. The reason for this was that the metaphorical and

sequencing elements of, for example, the six-part story method was difficult for clients with advanced dementia to follow. The impact of a person's cognitive decline changed the focus of the DT sessions. The dramatherapists began to do more task-orientated (familiar) activities in order to stimulate the person's memory. For example, Beatrice (DT) 'iced cakes' with one client. The picture they created on top of the cake was used as a catalyst for a story. With another client she renovated furniture. They spent time sanding and talking about his job as a carpenter. These sessions were about encouraging the client to share his/her life story, verbally and non-verbally through, a familiar activity.

With clients in the later stages of dementia, Beatrice (DT) and Susan (DT) used mirroring. They would mirror the movement their client made in the sand tray in order to create an initial connection with the person but also this would form the basis of a story.

> "I encourage the person to create a movement. For example, the person might make a pattern in the sand with their fingers and I might interpret that as the tracks of animal. In that sense I am projecting for them so I have to be careful of my own process and be aware of what I am doing. I take my cue from the sounds and movements the person makes. Sometimes the person makes it quite obvious that my interpretation is not right and at other times they may show me that they recognise my response to their sounds and movements. The person begins to take on a role, perhaps he/she becomes the seal in the sea etc… It is this middle part of the session where the story takes form. Often the person will get up and choose to use objects in the room rather than what I have brought, so we use those. Sometimes the person might want to fill the sink and then the session becomes about containing not overflowing, or he/she will use the edges in the room, you know, a lot of boundary work about edges and surfaces, different surfaces and textures and thresholds" (Susan, DT).

Sounding out of rhythms, encouraging eye contact by placing themselves at the person's level and repeating what the person had said were methods the DTs (and the other therapists) used to connect with the person. Susan (DT) and Beatrice (DT) both spoke about the importance of the sensory aspect of the work. They felt that a connection could be made with the person by encouraging him/her to touch and feel objects in their environment.

Final part of the session

There were two phases to the final part of the session. The first phase involved (to use a DT term) *'de-roling'* from the creative process and the second phase involved a *checking out* of the session. The first phase was discipline specific while the second phase was shared across the four disciplines.

Final part (phase one)

The arts therapists employed a number of different techniques to 'de-role' their clients from the artistic process.

AT

In AT the therapists and their client(s) would spend time reflecting on the images/artefacts that had been created during the session. With clients in the earlier stage of dementia the therapist might ask some open-ended questions: "How did you find the session today?" "Tell me a little about your image?" The person might speak about the image and then perhaps another member of the group might make a comment. All the images/artefacts created during the session were acknowledged by the client/group, although there was no requirement for the person to speak (if able to do so) about their work.

> "At the end we come together at the table and we go round and say, "How was it for you today?" Everyone is given space to talk" (Jenny, AT).

Heather (AT) said that her clients enjoyed looking at each other's paintings because it brought them into contact with each other's work.

In MT the 'de-roling' process would often take the form of the individual/group and therapist coming together for some singing. In DT verbal and non-verbal clients would de-role from the part they played in a story.

> "De-roling meant taking them back so, for example, if the person had a cloth around them because they had been doing something about the sea with cloth, or if the person had been holding something, it is about putting it back and thanking them for taking their role in the story, bringing them back to their name and the 'here and now' " (Susan, DT).

In DMT Grace and Sarah did a cool-down with their clients. Grace's (DMT) group did breathing exercises to classical music before then singing some old-time songs. Sarah's (DMT) group did unwinding exercises, such as shoulder roles. Freya's (DMT) group liked to listen to music while they relaxed. Kate (DMT) liked to end her sessions with everyone holding hands, singing and moving.

In DT Bernard (DT), working with more verbally able clients, would use the mascot figure that framed the beginning of the session to end it. His clients would talk to the bear, as they had done at the beginning of the session, telling it how they were feeling.

Final part (phase two)

This final phase of the session was called final *reflections.* After the singing, review of images or de-roling from the story the space would be left open for any final reflections. These could be shared verbally or just spent in silence. Grace (DMT) liked to end her sessions by getting feedback. She would ask her clients to say a word that represented how they were feeling.

Reflections with people with more advanced dementia might include touching the person's hand to acknowledge the end of the session or making a simple verbal statement like, "You looked happy." Steven (DT) said that so much depended on the person's ability to concentrate. Michael (MT) said that he liked to give his clients time prompts during the session to help orientate them through each phase of it. This meant that they had some idea of when the end of the session was coming.

Props, art materials and instruments

The arts therapists used a series of props, art materials and instruments in their sessions. In AT the clients used a mix of wet (paint and clay) and dry (felt pens, pencils) and sensory (textiles, nature and household objects, glitter, sequins and hats) art materials. In MT clients might use percussion instruments such as drums, beaters and maracas, pitched instruments like the harp, Glockenspiel and piano as

well as stringed instruments like the violin and the guitar. DMT therapists used pre-recorded music on CDs and props such as balls, parachutes, stretch cloths, scarves and hats, to encourage movement, and reminiscence objects to stimulate memory. DT participants liked to use a wide range of props, materials and instruments such as sensory art materials, pitched and stringed instruments as well as props such as masks, toy figures, jewellery and scarves plus household reminiscence objects such as baking tins and ration books.

Sally (AT), Romy (AT) and Heather (AT) highlighted the issue of when certain art materials should be introduced into a session. Romy (AT) and Heather (AT) liked to lay out a range of art materials prior to the session. They believed that it was an important way of orientating their client(s). Pamela (AT) preferred to wait until her clients were in the session so they could choose from the materials that were laid on the table. Sally (AT) felt that bringing out drawing (dry) materials too soon could be quite threatening for her clients unless they had previously drawn.

> "I don't give them drawing materials to begin with. It is usually collage. I put out little bowls of different things, sequins, feathers, things that they can touch. I get them to lay them out on the paper and then they might stick (them). So (I) introduce them gradually (to the art materials) through touching, feeling and smelling, sometimes then modelling and then I will bring out the dry materials" (Sally, AT).

Evaluation procedures

The arts therapists, in general, did not use formal evaluation procedures. Instead they employed more informal procedures. Three categories emerged: session by session evaluation; evaluating at the end of therapy; and how the therapists' own work was evaluated. Much of the evaluation process was the same across the disciplines.

Session by session evaluation

The arts therapists' session-by-session or ongoing evaluation procedures involved observing the client(s) in therapy and writing up session notes after each session. In terms of observations, Orla (MT) gave the example of how important these are in determining a client's response to a particular instrument or sound. Ongoing

evaluations typically would involve producing two sets of notes; firstly, their own process notes and secondly, a summary of the session for their client's case notes (kept in the setting). MT participants spoke about recording their sessions on something like a mini-disk. As part of the ongoing evaluation procedure the arts therapists would speak to other staff members about a particular client. If a staff helper was in the session then the arts therapist would speak with him/her and together they would reflect on the session.

I found that only Beatrice (DT), Heidi (DT) and Freya (DMT) used evaluation tools that were more formal. Heidi (DT) liked to analyse stories her clients created in the session using techniques from *narrative analysis*. This was a breakdown of the composition of the story, its sequence and how the person told the story. She said that in using narrative analysis she did have to consider how the story had emerged, for example, had she prompted the story or had it emerged spontaneously from her group. Beatrice (DT) spoke of using artistic evaluation tools such as full size body outlines drawn on paper. She used this to evaluate her client(s) ability to identify parts of their body. Freya (DMT) spoke of completing a movement analysis form.

> "We have got a form that we use in which we analyse the movement range. We would record the person's mood, perhaps the shift that we see in the person is a behavioural, physical and emotion shift" (Freya, DMT).

The form offered Freya (DMT) a quick reference point before the session. This saved her from having to search through her notes before each session.

Evaluating arts therapy work

Evaluating arts therapy work refers to the type of evaluation procedure in place after six months of arts therapy and the procedures employed at the end of the intervention. The arts therapists on permanent contract were often working with clients over a long period of time. They provided the setting with a written report every six months. In Sarah's (DMT) assessment ward she had to have a quicker evaluation process because her clients were short stay. She created a questionnaire that her early stage clients could complete with her or with a member of staff's help. She also wrote reports on each client she worked with. Other arts

therapists incorporated the use of questionnaires into their evaluation procedures. Generally these were for staff to complete, particularly if the client was in the later stages of dementia and the arts therapists were interested in the staff members' observations of the person's mood pre and post the arts therapy session. This type of evaluation worked for short-term work, however, evaluating long-term work was different, as Grace (DMT) acknowledges.

> "(Evaluation) is quite difficult in this setting. I give a report every year. They ask me to do a group report. I do a group one and individual one, what I consider the individual might need or would be helpful for them as well. But in terms of moving them on it is not really like that. It's a kind of underlying (assumption) that they are not going anywhere" (Grace, DMT).

The findings suggested that it was only the self-employed arts therapists that were able to discuss how they conducted a planned end of therapy evaluation. The reason for this was that the arts therapists, like Grace, on permanent contracts did not usually have a time limit for therapy, they continued to work with a person for as long as possible. In fact, often the ending of these sessions was very sudden and unexpected, for example, the client suddenly became too ill to attend or died.

For the self-employed arts therapists the therapy work evaluation usually involved the client participating in some form of therapy review (for those arts therapists and clients working over a longer period together the review might take place periodically throughout the year). In AT this would involve the client(s) and therapist reviewing the images (or a selection of the images) created during the sessions. In MT, DT and DMT there would be a revisiting of the favourite creative moment/activity. In order to prepare the client(s) for the end of the therapy work the arts therapist would give a countdown (a verbal or visual reminder of when the session would end). For the setting the arts therapist provided a written report evaluation of the arts therapy input.

Evaluating practice through supervision

Arts therapists evaluated their practice during supervision. Supervision is an important (and professionally required) part of the arts therapists' work, an opportunity for the arts therapist to reflect on the dynamics of the therapeutic relationship and their practice procedures with the support of a qualified supervisor.

> "I had regular supervision. I was able to bring issues to supervision, to talk about what I found difficult" (Steven, DT).

As the majority of arts therapists were not part of an arts therapy team they tended to have two forms of supervision: internal supervision by their setting line manager and external supervision with a qualified arts therapist. The external supervisor was usually from the same or a related discipline (e.g. trained psychotherapist).

> "I have supervision outside with a dance movement therapist so I will reflect with her and there is also the line management supervision" (Stella, DMT).

The arts therapists on permanent contracts, apart from Orla (MT), had their external supervision paid for them by their setting. Sarah (DMT), for example, was employed for six hours and the money from her sixth hour of work went towards her clinical supervision. Self-employed arts therapists generally paid for their external supervision themselves. This was quite an issue for many of the arts therapists because internal supervision by a non-therapist did not meet the professional accountability standards outlined by HPC. However, the cost of paying for supervision when undertaking part-time/sessional worked could be expensive. Orla (MT) had raised the matter with her employers (she was a permanent part-time member of staff) because she felt they were not meeting their obligation to her, in respect of paying for supervision.

Chapter summary

- The map highlighted that the arts therapists employed different referral procedures depending on where they worked. Hospital-based arts therapists used the standard formal written procedures used by all staff in the setting to refer a patient to services within the hospital. Community-based voluntary and private sector arts therapists employed less formal procedures. They had to establish their own procedures which could be difficult because of the diverse nature of the setting but also because the terms of their sessional or temporary contract meant they had limited or no periods of non-contact time to meet with clients and staff.

- ‘On the spot’ referrals of clients to the arts therapy sessions were common in the community-based voluntary and private sector settings. Arts therapists would invite their client on the day, just before the session, to come and attend the arts therapy session. This was done each week to check that the person did want to join the session and to reduce any potential anxiety or confusion the client may have about attending and to make sure the person had a choice in whether or not he/she wanted to participate. Another reason for the ‘on the spot’ referral was that planning ahead could be difficult if the person, for example, was not feeling well that day or had a pre-arranged appointment. The arts therapists had a policy of inclusion. They wanted to work with their clients for as long as possible. For self-referral, the patient would express an interest in attending the arts therapy session.

- The findings suggested that the arts therapists undertook a mix of both group and individual work with the DT and DMT undertaking more group work than the AT and MT. Often decisions to undertake group work were more setting rather than therapist led. In general, the trend was for group work with people in the earlier stages of dementia and more one-to-one work with those in the later stages. The dramatherapists, where group work predominates, reported that they did more individual work with their dementia clients than other client groups.

- In terms of the frequency and duration of the sessions. The arts therapists generally ran weekly sessions. Only one dramatherapist ran fortnightly sessions. The session length was anything from ten minutes to one hour for individual clients and one to two hours for groups. The number of clients in a group session was between five and eight but this varied depending on the setting.

- Medical/care staff helped in some arts therapies sessions. Therapists from across the disciplines, in particular DT and DMT, had a member of staff join them in the session to provide extra support with the group. Issues arose for some arts therapists around the selection of an appropriate member of staff. In some settings the staff helper was randomly assigned to the group

depending on who was on shift that day. This could be challenging if the staff member was unclear about the aims of the arts therapy session and if he/she had no desire to be there. In settings where the staff helper could attend regularly and understood the aims of the session, the arts therapist found this additional support very valuable.

- The findings suggested that the arts therapists were engaged to varying degrees in informal and/or formal assessment procedures. Informal assessment procedures involved the arts therapist observing the client in session, seeing how he/she engaged with the art form and with the therapist/group. Formal assessment procedures were used primarily by the dramatherapists and drawn from mainstream DT or OT practice. Many arts therapists offered one off 'taster' sessions for clients to see if the person might enjoy participating in the arts therapy session.

- In theoretical terms, the arts therapists employed an integrative/eclectic mix of psychotherapeutic, artistic and other theories. Many of the theoreticians and theories informing the arts therapists' practice drew from the mainstream arts therapy field, although there was evidence that theories specific to arts therapy and dementia practice were also used.

- The findings suggest that the arts therapists employed a similar session structure. There was a two-phase introduction to the session that involved orientating the person to the therapy space and to the group, then engaging the person in the art form (e.g. perhaps re-introducing the props, art materials, instruments). The central part of the session was improvisatory in that the client and arts therapists worked in ways that were often unique to their situation (e.g. doing a group painting, working with a story). There was a two-phase end to the session that involved de-roling the person from the art form and reflecting on the process.

- Arts therapists employed informal evaluation procedures. Ongoing procedures involved writing up session notes after each session. Arts therapists on permanent contracts provided the setting with a written report every six months, while those on short-term contracts provided a written

report at the end of the work. The arts therapists were required to undertake professional supervision.

Chapter Ten

Reflections from the Arts Therapists

Overview

The previous chapter ended with a description of how the arts therapists evaluated their own work through supervision. Reflecting on his/her work practice is a key part of the arts therapist's job. This chapter discusses the reflections the arts therapists made on their work. Consideration is given to what the arts therapists perceived to be the significance of the arts therapies for their clients. The chapter moves on to consider the arts therapists' thoughts on interdisciplinary working and their personal reflections on the rewards and challenges of the work as well as other therapy work comparisons.

Significance of arts therapies for clients who have dementia

The arts therapists perceived that participation in the arts therapies was beneficial for their clients. Table twenty-four highlights the seven key benefits (not in hierarchical order) that engagement in the arts therapies afforded the person.

- Purposeful engagement
- Skill acquisition
- Relational interaction
- Structuring
- Communication/expression
- Reminiscence
- Choice
- Validation.

In terms of *purposeful engagement,* Sarah (DMT) and Heather (AT) commented on the benefits of taking part in a purposeful activity - a meaningful activity that situates

the person in an active rather than passive role. Heather (AT) spoke about her clients, on the female ward, knitting during sessions. She brought in knitting needles and wool at the request of one of her clients. She observed that the women were purposely engaged again in an activity that had once been an important part of their lives. Kim (AT) talked to her clients about learning something new (*skill acquisition*) when they came to the arts therapy session. Picking up a paintbrush, playing an instrument were new skills for many of the clients.

Relational interaction was viewed by the arts therapists as fundamental. Making contact with the person through the constancy of the sessions facilitated the development of a trusting and supportive relationship. Through the relationship the person could engage in creative expression and through the conduit of the art form end of life issues could be explored. Some clients just enjoyed the process of socialising with others. The notion of helping the client to structure him/herself through engaging in the art form was perceived as a benefit of the arts therapies session. Hope (MT) spoke about MT being a connector between the client's different realities. Stella (DMT) noted that DMT was helpful in moving the person out of his/her restricted and often repetitive patterns into a new set of patterns.

Communication/expression also was perceived by the arts therapists as one of the most valuable benefits of the arts therapies for client who have dementia. Jasmin (AT) talked very powerfully about the AT sessions offering her clients the chance to leave their mark. When words were failing the person there was the opportunity for sensory expression through the art materials. Emma (MT) spoke about music offering her client a conduit through which she could express her feelings. Her client had become aphasic and she was finding it difficult to express how she was feeling. Emma (MT) spent time with her client improvising different songs until her client found her voice through song. Steven (DT) said that person's memories (reminiscence) were often spoken about in the sessions, perhaps within the context of a story. Ray (DT) commented that a thimble used as a prop in a DT session might remind a client of the dress that she made for her daughter. This offered her a way of connecting with this important past memory. Claire (MT) suggested that having access to both verbal and non-verbal forms of expression helped her group explore the stuckness that could happen during group improvisation.

> "I think that one of the things that often happens in group improvisation with this client group is a kind of limitedness or stuckness of people hanging on to a kind way of being which they are reluctant to let go, so there is quite a lot of exploration both musically and verbally during the process" (Claire, MT).

For many clients their abilities outside the session were different to their abilities inside the session. Helen (AT) said that her client who was very disruptive outside the session came to her session and drew the same lined image each week. She had a sense that AT was connecting with him. Kate (DMT) similarly gave the example of a client in the unit where she had worked who had a reputation for being quite difficult, the person would hurl abuse and be quite aggressive towards staff. Kate (DMT) invited her to dance and her husband who had arrived to see his wife partnered her in a dance.

> "I asked her to dance and to my amazement she got up. Then we asked her husband to partner her which he did and the amazing thing was that they began to talk as if they were 20 year olds; up until then I had never seen her walk a step but they waltzed slowly around the room, talking I presume from a conversation from decades before. The staff then set out a table for afternoon tea and they had afternoon tea together and chatted." (Kate, DMT)

> "The staff must have been amazed." (Jane)

> "I had only seen her hurl abuse or be asleep. She had never participated in any sessions at all and her husband said afterwards with tears in his eyes 'you gave me my wife back' and that was purely the movement. He got up he held her and in my head it seemed to me that experience of being with him waltzing seemed to access the healthy part of her brain. So that is the bit that really interested me because I have seen it happen before" (Kate, DMT)

Table 24 – Significance of Arts Therapies for Clients who have Dementia	
• My clients say it is really nice to have something to do (Sarah, DMT). • They give people a sense of active agency in their environment rather than just being passive observers (Heather, AT).	Purposeful engagement
• There is the opportunity to learn something new when they are failing in other areas of their life (Kim, AT).	Skill acquisition
• It is space to be with people, to have a laugh, to join them wherever they are at (Laura, DMT). • The sessions offer the client the opportunity for social change as the person is no longer isolated within the home (Beatrice, DT). • There was always time for everybody. As they got to know me they knew I was not going to rush off to take someone to the toilet. As a result it felt like a very safe space (Kate, DMT). • We can give our clients an hour of our time and we will listen and be with them. I think that kind of relationship is really important (Sally, AT).	Relational interaction
• It is about getting people out of their restrictive patterns and into old patterns (of moving/dancing) or into new patterns (Stella, DMT). • Often their sense of their external world has become fractured and meaningful verbal communication is problematic. Music can offer the means of building a bridge between two very different realities (Hope, MT). • The artwork provides a holding memory even when much else of the session or day is forgotten (Alexander, AT). • DT works well with elderly people because it connects them to memories which rely on images from the past and familiar objects. People can latch on to these where their memory becomes fragmented (Ray, DT). • I really noticed at the beginning of sessions I would find that my clients would be quite curved and introverted, they took up little space but after a number of sessions they knew where they began and ended physically. They knew that they still had fingers, toes and knees, they knew how much space they took up and were allowed to take up (Kate, DMT).	Structuring/ connecting
• AT offers a means of communicating thoughts and feeling which may be impossible to verbally articulate (Alexander, AT). • AT offers a way of expressing the frustration of not being able to communicate verbally. My research suggested that through the art my clients were able to express their feelings of anger, shame and guilt, feelings that would otherwise have been expressed through inappropriate behaviour (Jasmin, AT).	Communication Expression
• It is a space where they are not told to do something, where there is no right or wrong (Susan, DT).	Choice
• AT helps with self-esteem, the person has a sense of being valued, having time and being in control of what they are doing (Jenny, AT).	Validation

Kate's (DMT) example illustrates the innate creativity that can be tapped into by the arts therapists. It is hard to imagine but outside the session Kate's (DMT) client was unable to speak and could only make minimal movements. The phenomenon that Kate (DMT) describes is a common feature of the work.

Rewards of the work

The arts therapists spoke of the rewards of the work. Many commented on the work being enriching. They spoke of the deep relational bonds they had with their clients. Sarah (DMT) said that the relationship between client and therapist was often very intimate, very moving. She felt it was a privilege to accompany her clients on their journey, at this point in their life. The arts therapists felt it was a privilege to be a witness to their client(s) life. Jenny (AT) spoke of each person's journey being different. She said that sometimes it could be difficult to make a connection with a person but when that connection was made and the person had a sense of being understood then the work was very rewarding.

Many of the arts therapists spoke of the tremendous learning experience they had when working with a person who has dementia. Kim (AT) felt that her clients had so much to teach her about life. Claire (MT) and Susan (DT) said they had learnt something about what it meant to be a human being. The whole process of dementia challenges our notion of the human experience and tests our understanding of how others perceive that experience. Stella (DMT) spoke of the hope that the work engendered. She said that for her, dementia was not a downhill condition where there was no hope for the person. She said that the person could be stable for a long period and there was always the possibility of improving some aspect of the person's life.

Several arts therapists spoke of the work being very exciting. They never knew where a session would go. The work was very much in the 'here and now' and so had the potential for anything to happen. Sarah (DMT) spoke of the work being very non-judgemental. Her clients were very accepting of DMT, an intervention that was new to them. Janice (DMT) and several of the arts therapists commented on how funny the work could be. With age comes, for some, the freedom to say and

do anything that comes to mind. Janice (DMT) spoke about her group gently teasing her if she introduced something new to the group or about the fact that she was not their age. Many of the arts therapists spoke of enjoying the social aspect of the group, the banter and humour that accompanied the work.

Challenges of the work

There was a sense for the arts therapists that with the rewards also come challenges. The arts therapists faced many challenges both inside and outside the session. Inside the session they spoke frankly of their struggle to hold the therapeutic relationship as the disease took hold. The arts therapists spoke of their distress at seeing their clients deteriorate. Heather (AT) said that working in this field touched on her fear of chaos. Orla (MT), too, spoke about the fragmented and disconnected nature of the work. Each session is like a single session, a moment in time that cannot be repeated, making it difficult to establish a continuum. Michael (MT) said so much of the work was about the *not knowing.* Romy (AT) said that so much of the work is just trying to work out what is going on. She commented that it could be difficult to stay with a person when their logic is fluctuating. Romy (AT) said that you could never make any assumptions about the work. Orla (MT) commented that she was unsure what her clients got out of the work.

The work challenged not only the arts therapists' professional knowledge in terms of working with end of life issues but also the core of their professional identity. Theoretical principles and methods that had been learnt over many years could often not be applied in this work. Therapy boundaries were often difficult to maintain. Bernard (DT), for example, was invited to have lunch after his sessions with the clients. He felt unsure about what to do because traditionally therapists would not stay after a session for lunch. The unit manager persuaded him that staying would be good for the group, helping to establish him in the setting. Bernard (DT) said that he often felt the weight of his professional expectations on his shoulders but the reality of practice could be different.

The work could be very emotional. Many therapists felt emotionally drained by it. Ben (MT), Kate (DMT) and Pamela (AT) had recently left the field because they had become 'burnt out'. Pamela (AT) and Ben (AT) spoke of the work having an

element of stuckness, the work becomes repetitive with clients playing the same tune, drawing the same circle over and over again. As clients deteriorate they became dependent on the therapist for help with everything. Lifting a paintbrush, holding a tambourine. Pamela (AT) and Ben (AT) said that they were able to cope with some of these aspects of the work but not when these were coupled with the complexity of working in such a difficult environment. Ben (AT) and Heather (AT) spoke of working in not very pleasant environments. I visited Heather's setting. It was very unpleasant, like a dark dungeon. Paint was peeling off the walls and all the clients were clustered into one sitting room.

The arts therapists felt under pressure from the settings to work with a certain number of clients (one reason why group work outweighed individual work). Rebecca (MT) said that as an NHS arts therapist she was expected to come up with positive outcomes, but everyday work in the dementia field could not, she believed, provide positive outcomes because of the progressive nature of the disease. She commented that if she worked only in the dementia field then it would be difficult, working for the NHS, for her to feel valued. Michael (MT) commented that the work could challenge him in different ways. For example, his dementia clients (recently diagnosed) used far more verbal language than his other clients. They ask him direct questions about therapy such as, "Is this like seeing a priest?" "How confidential is the therapy?" He has to answer these questions.

Interdisciplinary work

The arts therapists reported mixed feelings about interdisciplinary work. As the findings have suggested, the majority of the arts therapists were working on their own in the setting. Rebecca (MT) and Orla (MT) spoke of their professional isolation. They had no colleagues from their discipline to discuss their work with. Medical/care staff were, generally, unfamiliar with the work of the arts therapist. Agnes and Mary, two care staff that I interviewed, said that before the current arts therapist started they had never heard of an art therapist before. They thought they were getting another activity officer. It took the arts therapists and staff time to learn about each other. For Orla (MT) it was a case of finding a sympathetic member of staff and liaising with them with regards to her clients. Claire (MT) said that if she had an issue she would try and find out who was in charge of the shift

and thrash it out with them. She said the managers where she worked were supportive. She found the nursing staff more difficult to work with. This comment was echoed by many of the NHS employed arts therapists who similarly found their managers and other AHP staff generally fine to work with but nursing staff difficult. They were often much less respectful of the confidentiality of sessions, would interrupt sessions and generally were not very understanding about other ways of working. This was not the case in the smaller community residential and in particular day units. The staff group was smaller and a therapist could eventually get to know everyone. Much of the early work of the therapist was about gaining acceptance among the staff team and establishing trust.

> "In the past the staff used to say that John was too upset or agitated to come to music therapy. I would say, 'Hang on a minute, let me work with John and see if I can reduce his agitation.' That was what happened. Staff recognised that I could help" (Emma, MT).

Once the arts therapists had been accepted by their respective staff teams, they spoke of feeling valued by their colleagues. The staff I interviewed felt that their arts therapist brought a different, creative, element to the setting. Carla reported enjoying "something different happening in the unit". Beatrice (DT) offered open DT sessions in which both staff and client could participate. Kim (AT) and Bernard (DT) spoke of how much they enjoyed working as part of an interdisciplinary team. There were opportunities of sharing knowledge, presenting to colleagues and learning how others worked.

Comparisons with other arts therapy work

Claire (MT) commented that, "This type of work is very different to any other." Claire's (MT) thoughts were shared by a number of other arts therapists. Susan (DT) commented on how uncomfortable or scared some arts therapists were about working in this field. She said that in this work you are forced to ask questions about your own identity such as, "Do you really exist when your mind goes?" "What happens to your subjective sense of self when you have dementia?" Susan (DT) believed that the work required the arts therapist to make a shift in how he/she perceived his/her client; for example, not seeing the person's fragmented language as incoherent but rather as words of wisdom, often profound. Claire (MT) said that she felt that a person with dementia is hugely dependent on the capacity of other

people to provide a context of validation; it was her role to validate her clients' experiences, rather than providing a platform, as she did with her other client groups, for her clients to learn to validate their own experiences. Alexander (AT) said that working in this field challenged a lot of his assumptions about what can be communicated within AT. He had learnt a lot of new skills such as using touch as a form of communication, his proximity to his clients, the type of art materials that were used, how to decipher the language of his client, using eye contact.

> "(What I learnt in this work) has helped me to be more receptive to other client groups, to be aware of the assumptions I, myself as a therapist, make" (Alexander, AT).

Grace (DMT), Rebecca (MT) and Michael (MT) spoke of the different concept of themselves that they had when they worked with their dementia clients (compared to their work with their other client groups). For example, all of them were much more interactive/social with their clients who have dementia. Grace (DMT) said:

> "I am very different (in the dementia setting) to how I am elsewhere. On some level I need to be able to disclose parts of myself and meet my clients as a person rather than someone who is quite distant, just allowing them to bring their own issues. I go into the setting and meet my dementia clients. I will share quite a bit about my personal life and they will engage with that and share their own story" (Grace, DMT).

In order to accommodate this change in working style, Grace (DMT) had made a theoretical shift moving from psychodynamic ways of working she reserved for her DMT forensic work to working in a more person-centred way with her clients who had dementia. Michael (MT) and Rebecca (MT) spoke similarly about engaging more with the person. For example, they would not hold back when they were asked a personal question as they would do with other client groups. Rebecca (MT) said that her clients found her terribly young, something that was never mentioned by her other clients.

Chapter summary

- The arts therapists perceived that the key significance of the arts therapies for clients with dementia were: *Purposeful engagement, Skill acquisition, Relational*

interaction, Structuring, Communication/expression, Reminiscence, Choice and Validation.

- The arts therapists felt that the work was enriching, exciting and deeply moving. They felt privileged that they had the opportunity to accompany the person during this period in his/her life. Many of the arts therapists spoke of the tremendous learning experience that the work provided. They said their clients taught them so much about life.

- In terms of challenges of the work, the arts therapists spoke of their distress at seeing their clients deteriorate. The work could be very emotionally demanding. The arts therapists commented on the often fragmented and disconnected nature of the work. A lot of time was spent just trying to work out what was going on. At times it could be difficult to know what the clients got out of the work. The professional knowledge of the arts therapists was challenged in that the theoretical principles and methods that had been learnt over many years often could often not be applied to arts therapy work with people who have dementia.

- The arts therapists had mixed feelings about interdisciplinary work. The majority of the arts therapists were working on their own and not as part of an arts therapy team. Fitting in with a different culture could be difficult. It took time for the arts therapists to establish him/her self in the setting, particularly the hospital setting. When alliances were formed with medical/care staff these proved to be very value opportunities to share knowledge and get support from other colleagues.

- The arts therapists commented on the work being different to other types of arts therapy practice. Working with older people who have dementia posed existential questions, for the arts therapists, about the nature of human existence. One art therapist felt that a person with dementia was hugely dependent on the capacity of other people to provide a context of validation, more than other client groups. Arts therapists learnt to communicate differently with their clients. One art therapist commented that he had learnt to use touch

as a form of communication, he was more aware of his proximity to his clients and used eye contact to understand what his clients wished to communicate.

Chapter Eleven

Discovering the Patterns of Practice

Overview

Chapters seven to ten provided the descriptive map of arts therapies practice with older people who have dementia. In this chapter the focus of the study changes from mapping to interpreting as I offer my reflections on the overarching patterns emerging from the descriptive map (Table 25). The patterns discussed here are, to my mind, the most pivotal. Mapping the arts therapies and dementia field provided me with many paths for exploration so choices had to be made in terms of the direction that was finally taken. The interpretations are discussed where appropriate in relation to the literature reviewed in this study however not all interpretations are supported by the literature due their newness.

I begin this interpretive chapter with my reflections on my changing role within the study.

Reflections from the practitioner-researcher

Insider - outsider - insider

The term practitioner-researcher was unfamiliar to me until I started this research project. I realised one day as I began reading about methodological approaches that my starting point for this study was different from that of the new to the field researcher (Chenail et al.1997). Having *a priori* knowledge of the field meant that I brought to the study a set of assumptions and values that I needed to reflect upon. I wondered what impact my *a priori* knowledge would have on the participants. From my own perspective I took some initial comfort from the fact that I was researching a topic that had been of interest to me for some time. I had a good understanding of the AT and dementia field and although less familiar with MT, DMT and DT, I

understood that we shared a core belief in the healing potential of the arts and the value of realising that potential within a person-centred relationship.

As a practitioner-researcher doubts abound as to how your participants will respond to you. I wondered how the MT, DMT and DT therapists would respond to my intrusion into their discipline. Furthermore, I wondered how they would receive a research project looking at their practice. Traditionally there has been an active disregard for research among the arts therapies. Historically, the positivist research tradition alienated practising arts therapists from participating in the research process. Arts therapists saw no way of sharing their subjective experiences of the therapeutic relationship within such a paradigm. A few arts therapists took up the research mantle with the emergence of the post-positivist paradigm but despite this increase the number of arts therapists involved in research is still limited.

I speculated that I might be perceived as an 'insider' by the AT participants and as an 'outsider' by the MT, DMT and DT participants. However, during all the interviews with all the arts therapists I felt very comfortable and they appeared to feel comfortable with me. I had a sense that they all responded to me as if I was an 'insider'. I was struck by the honesty of the arts therapists that I interviewed and their willingness to share their story. Some of the arts therapists were grateful to have someone to talk to about their practice. Orla (MT) for example, said that she found the interview very helpful because it made her think about her practice. She was unhappy in the hospital where she worked and was contemplating leaving her job. The only other person she had to talk to was her supervisor and her supervisor did not work in the field. I was struck by the arts therapists' sense of isolation and this awakened in me my own memories of working on my own. I felt like an 'insider' when the arts therapists said things like, "You know how it is" or "I am sure you understand." At times I wondered if I did know how it was for them. During the first couple of interviews I felt almost embarrassed to ask some basic questions about their discipline because, to my mind, this was something that an 'insider' should already know.

As I interviewed participants from MT, DMT and DT I became more and more fascinated with each discipline as I learned how they worked. From the music therapists I learned about improvisation and how music can be used to bring the

therapist and client into dialogue with each other. I learnt that rhythm can help to structure the person and this made me think of all the circle images my clients had made over the years and how rhythm is implicit in the movement of the hand and the pastel on the paper. I liked the creative potential of the DT sessions. Each session was tailored to the particular client(s), a variety of different techniques and props were used, sessions felt very dynamic and creative. In DMT I was interested in the way the dance movement therapists mediate between the external and the internal, the physical and emotional self. I had not previously thought about the person's posture, breathing, importance of human contact or touch or how clients might fear making physical movements. The fear of falling, I realised, had the potential to overwhelm the person and make him/her withdraw from the world.

I realised that there were other artistic ways of working with the person. I felt that my role changed in that I moved from being an 'insider' to being an 'outsider'. Colleagues who have undertaken such research projects described to me a period of deconstruction that happens when the practitioner-researcher's existing knowledge is challenged with alternative knowledge of the field. This I found was quite an anxiety provoking stage of the project. At times I felt overwhelmed, unsure how I was going to reconstruct the old and new knowledge into some potentially meaningful practice knowledge. After many months in the fog of the analysis the mists did eventually begin to clear when I began to write about what I had found. I began to feel like an 'insider' again but this time an 'insider' with a different perspective. I was an 'insider' in terms of the research project but an 'outsider' in terms of being a practitioner. I had to, as Hill (2006) suggests, move outside the field in order to understand it better.

Interpreting the descriptive map

Table twenty-five highlights the analytical development of the study from the descriptive map to the final interpretive patterns. The final interpretive patterns are supported by the emergent interpretive patterns (e.g. those bridging the descriptive map and the final interpretive patterns).

Table 25 - From Descriptive Map to Interpretive Patterns			
Label	Descriptive map	Emergent Interpretative Patterns	Final Interpretive Patterns
Background	Coming to the field Dementia work	Mosaic of prior training and career Polarised motivations about working in the field Fluctuating employment	Rocky Road
Client	Psychological/ emotional	Feeling disconnected	Needing to feel connected
Setting	Role in the setting Setting issues Therapy space Boundaries and Confidentiality	Pioneers Being unheard Staying unheard	Power dynamic
Therapy Work	Referral Assessment Evaluation	Procedures	Adopting/adapting
	Theoreticians/theories	Integrative/eclectic Psychotherapeutic Artistic/Other	
	Methods	Temporal session structure ↓ Multi-methods ↓ Constancy in temporality	↓ Emergent practice
Therapists' Reflections	Challenges Rewards	Staying with the not knowing Learning from the client	Life Lessons

The rocky road

The arts therapists travelled on a *rocky road into the dementia field.* Their journey into the field was a mosaic *of prior training and career.* Post arts therapy training they entered the field with *polarised motivations* about working with older people who have dementia. Once in the field they faced the prospect of *fluctuating employment* as they tried to secure work. All of these elements equated to a rocky road for the arts therapists.

I reflected that the professional background of the arts therapists was like a *mosaic,* in terms of their *prior training and career.* "Mosaics are designs or pictures created by embedding small pieces of glass, stone, terracotta into a bed of cement" (Mosaic Matters, 2008, p.1). The idea that each piece within the mosaic is distinct yet comes together in one design reminded me of the individual journey that each participant had undertaken to become an arts therapist. The individuality of each arts therapist's prior training was highlighted by the diversity of undergraduate degrees that the AT, DMT and DT participants had. Firstly, the DT and DMT participants had undertaken undergraduate degrees in a variety of subjects, not primarily in the art form. This study indicates that only two out of six dramatherapists and two out of the seven dance movement therapists were qualified in their respective art forms. For the DMT this was even less than Karkou's (1998) finding that thirty per cent of DT and DMT participants had trained in the art form. However, the AT participants fitted Karkou's (1998) profile as half of them had undertaken a first degree in an art related subject. The music therapists in this study exceeded Karkou's (1998) fifty per cent margin in that they all had been trained in music. In this respect I interpret that the music therapists sat apart from the general arts therapy trend because all of them, one hundred per cent, had a first degree in music.

In terms of prior career, the pattern in this study was similar to that identified by Karkou (1998) in that the AT, DMT and DT participants worked in a variety of different professions before undertaking their postgraduate arts therapy training. In fact, only eight of the arts therapists had both trained and worked in their respective art form. The remaining arts therapists worked primarily in the helping professions. The professional background of AT, DMT and DT participants sat in contrast to that

of the music therapists. All but two of whom went from undergraduate training straight into MT training. In the absence of any literature confirming why this distinction exists, I wondered if it had something to do with the general preference for AT, DT and DMT training courses to take more mature students of twenty-six years and above. Rebecca (MT) told me that MT training courses often take students straight from their undergraduate course because they are newly skilled in the art form.

The map illustrated that deciding to train as an arts therapist involved the participants making many life changes. These typically saw them moving from a traditional full-time job such as teaching to a part-time, often sessional, job as an arts therapist. Why, I wondered? I think Sarah (DMT) gave one reason when she said, *"I found it was just what I had always dreamed of doing."* For Sarah (DMT) the work was a kind of c*alling*, more than a job, something removed from the norms of traditional working. She had dreamed of working in dance.

I was struck on re-reading the descriptive map how much easier the decision was for arts therapists, like Sarah (DMT), to give up their prior careers and to enter an unknown discipline like the arts therapies than it was for them to make the decision, once qualified, to work with older people who have dementia. The US art therapist Spaniol (1997) touched on the "paradox" facing art(s) therapists in respect of job availability versus job desire. She noted that job opportunities in the US for art therapists were limited due to funding, but that there was the potential for future jobs due to the aging population. The paradox, however, was that many art(s) therapists might be reluctant to take up such job opportunities because of feeling "culturally incompetent" (Spaniol, 1997, p.158). I had a sense that Spaniol's (1997) statement could be applied to the arts therapists in this study. Coming to the arts therapy field was a "dream" for many arts therapists but this contrasted sharply with their often haphazard sometimes reluctant (in the sense that there were no other jobs/placement available) journey into the dementia field. Incredibly, only seven out of the thirty-one arts therapists interviewed had any prior motivation (professional or personal) to work with this client group. Grace's (DMT), comment that "*I wanted to work in schizophrenia or something similar"* hinted that her initial perception was that the work lacked the glamour or 'sexiness' of working in say adult mental health. Grace's (DMT) honesty about her initial feelings towards her older clients with

dementia made me think of Tyler's (2002, p.69) description of the older person as a "persona non grata", someone who does not fit into a society obsessed with age and beauty. It is only within the last eighteen years that perceptions of the older person have begun to change in the dementia care and psychotherapy fields (Kitwood, 1988, 1989, 1990, 1993, 1997; Kitwood and Bredin 1992; Kitwood and Benson, 1995). For some it is questionable how extensive these changes have been on the ground (Bender, 2003). It is hardly surprising, then, that professionals coming into the field might do so with some reluctance and may indeed feel "culturally incompetent" (Spaniol, 1997, p.158) to deal with this largely unknown client group. It was interesting to note that Grace's (DMT) initial reservations disappeared once she felt culturally competent in the field.

It is, perhaps, not difficult for the reader to envisage how the theme of *polarised motivations* emerged during the analysis; the arts therapists after all were coming to work with a group of people who, until the 1990s, had literally been 'forgotten' by society. For the arts therapists interviewed in this study it appeared that the sad reality was that so few of them, only eighteen out of thirty-one, had managed to sustain between two and ten years employment in the field. This would suggest that there is a pattern of *fluctuating employment* in the field. The descriptive map highlights that funding was the primary reason why the thirteen arts therapists were not currently in the field, although there were other factors such as feeling 'burnt out' and professionally isolated that made arts therapists leave the profession.

I was interested in the notion of the arts therapist feeling 'burnt out' and wondered, from a psychodynamic perspective, if this was less to do with the pressures of the job and more to do with the arts therapist's own unconscious feelings about not being able to tolerate the death of his/her client and perceived hopelessness of the situation. As this study has illustrated working with clients at the end of their life was challenging for the arts therapists because it evoked feelings about their own mortality.

In terms of feeling professionally isolated it is interesting to consider if some of the arts therapists unconsciously maintained their state of professional isolation in order to stay removed from the care setting culture. Waller (2002) observed that medical/care staff can become de-sensitised to the needs of the person because of

the care setting routine. The arts therapists, by distancing themselves from this routine, could stay fully engaged with their clients

Practical issues, primarily, underpinned the arts therapists fluctuating employment. Beatrice (DT) and Heather's (AT) work was cut short when there was a change in management and care setting. The precariousness of the employment situation for the arts therapists was highlighted for me by the fact that part-time and sessional work was so unstable. In other professions job instability might mean a change from full-time to part-time work or change in work place. This study, like Karkou's (1998) research, highlights the limited availability of permanent full-time employment for arts therapists. The descriptive map illustrated that many of the arts therapists were working/had worked in the voluntary or private sector in a time-limited capacity. In fact only three of the art therapists had managed to secure permanent part-time contracts. Why? One reason was that art therapists represented the largest group so naturally they reported the highest number of non-permanent posts. Another reason could be linked to the art modality itself and the need for a particular type of therapy space. AT can be messy; paint splats, pastels smudge and clay dust invade every crevice. Art therapists require access to sinks and need to work in uncarpeted rooms. Perhaps these factors deterred employers from hiring art therapists? In some smaller settings the type of space available certainly was an issue but this was not a major finding in this study. Moreover, DMT and DT participants working in voluntary or private sector settings experienced the same difficulties when they tried to secure permanent posts. I think the answer is that traditionally these types of organisation have offered work to AT, DMT and DT arts therapist particularly in certain parts of the country, like Scotland. These organisations are often the most under-funded and so least able to afford an arts therapy service.

The descriptive map highlighted that the situation for music therapists working in the voluntary or private sector was different to that of the AT, DMT and DT participants. Music therapists, unlike the other arts therapists, were also employed by a MT trust which contracted them out to NHS, voluntary of private sector employers. Could AT, DMT and DT trusts be established to do the same? At present MT is the only arts therapy backed by such a charitable trust. The reason is that MT has a much wider public profile than the other arts therapies, music

appeals to a large spectrum of people because it is something so familiar and for that reason people happily donate to music charities. Art, dance and drama are distinct because they are popular with certain sections of society and therefore do not appear to attract the same level of public support. In theory this means that there is less potential for each of these disciplines to establish their own trust. This is a topic worth further consideration because if such trusts could be established then AT, DMT and DT therapists might enjoy more job stability.

Despite this unsettled picture there was evidence from the descriptive map to suggest that AT, DMT and DT participants working in the NHS had found job stability in the form of permanent part-time post. The music therapists, the largest number of NHS employed arts therapists, had also secured the most permanent part-time posts. The reason for this was that historically music therapists were the largest group of arts therapist working in the NHS. In fact all the music therapists had part-time permanent posts thanks to either NHS or MT trust employers. It is interesting to reflect that this situation sets the music therapists apart from the other arts therapists. The music therapists have never been employed on temporary contracts and as such prospective employers always negotiate part-time permanent contracts with new MT employees. AT, DMT and DT participants need to improve their long-term employment opportunities by firstly, increasing awareness of how they work in practice and secondly pressing their professional representatives to target employers offering permanent contracts rather than employers wishing to employ them for short-term work.

The reality for all the arts therapists was that they had to supplement their part-time work with other part-time arts therapy or non-arts therapy work. This made me wonder why they did not choose to work with another client group (e.g. children or adults with mental health problems) where there was at least the potential for more job stability. I wondered if the arts therapists had become seduced by the work. Working with a person at the end of his/her life is a very powerful experience. The arts therapists may have found the work difficult to forget. Certainly, I was struck by how many of the participants who were no longer working in the field wanted to take part in this study.

Needing to feel connected

The literature review and the arts therapists interviewed spoke overwhelmingly of a client group *feeling disconnected* from the world around them. The study illustrated that the person who has dementia does not feel disconnected because of the disease dementia, although undoubtedly a factor, but often because of the lack of psychological and emotional support available to the person. Kitwood and colleagues' (Kitwood, 1988, 1989, 1990, 1993, 1997; Kitwood and Bredin, 1992; Kitwood and Benson, 1995) *new culture of dementia care* awakened professionals to the need for better care service provision for the person, in particular more person-centred care (Marshall, 2001). However, medical/care staff are often caught up in the routine of the care setting and may struggle to find a space in their busy day to spend quality time with the person (Waller, 2002). One of the primary issues is that medical/care staff (despite of developments in person-centred care) work within a routine that was established long before psychosocial ideas came to the fore. When the person becomes part of the routine it is hard for him/her to maintain a sense of self, to feel connected to other people and the environment. Miesen's (1999) thoughts on parent fixation highlight what happens to the person when he/she begins to lose a sense of self feelings of anxiety are evoked and if not addressed then the person actively goes in search of a secure attachment figure. If the person cannot find his/her secure attachment then he/she withdraws (Wilson, 1997). Reflecting on the descriptive map it would seem, therefore, that the overall objective of the work was to help the person feel connected to a sense of self, the people and the environment around him/her (Figure 1).

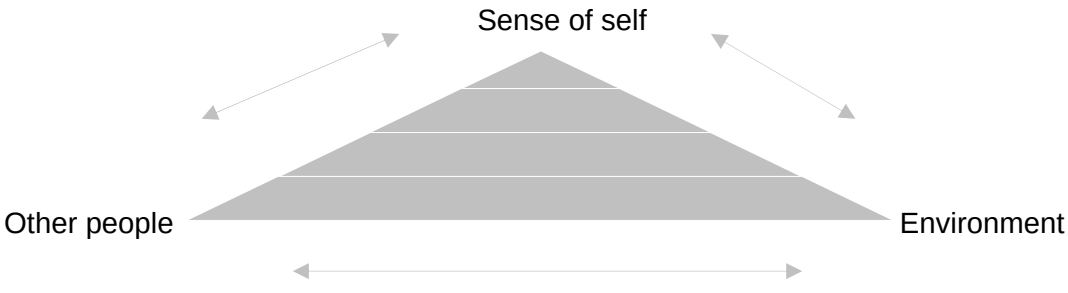


Figure 1 – Objective of the arts therapies

The primary ways in which this objective was achieved was through *Reminiscence, Purposeful Engagement, Skill Acquisition, Relational Interaction, Structuring, Communication/Expression and Choice and Validation*. Working with the art form offered a way for the person to be purposefully engaged in a meaningful activity that offered a learning opportunity. Relational interaction afforded the person the potential of a new kind of relationship. Kitwood (1997, p.98) described this as "…a special kind of relationship… one that is more tolerating, accepting and stable than normal relationships." Sarah (DMT) spoke of being in a privileged position, in the sense that she had the luxury of time to establish a connection with the person. Spending quality time with the person enhances the potential for his/her experiences to be validated. Learned helplessness (Seligman, 1975) is challenged when the person becomes part of the choice making process. The study found that clients attending the arts therapy sessions benefited from being part of the group. This seemed to fit with Johnson et al's (1992) finding that participating in a group activity afforded clients an important opportunity to socialise and spend time with other people. This study has illustrated that such interaction may help to break down barriers of isolation in the care setting and encourage clients to view their environment differently (e.g. to know the person living in the room next door).

In terms of expression, engagement in the art form helps facilitate the person's verbal and non-verbal communication. This is because the image, the story, the movement or piece of music adds a triadic element (Wilks and Byers, 1992) to the dyadic client therapist relationship. The symbolic and metaphorical quality of the art form can reach the person on many different levels, levels that can be peeled away or left unpeeled (Miller, 1984). The person is given structure through the art form because it taps into his/her innate sensory and rhythmical structures. For Aldridge (2000) this meant bringing the person into his/her time structure. In DMT, the person could find structure in movement patterns and reminiscence movements (Sandel, 1978; Arakawa-Davies, 1997; Coaten, 2001), in AT through the sequencing of the image and in DT through the episodic quality of the story (Casson,1994; Batson, 1998). Through this structuring the person is afforded a sense of his/her self as someone active and creative. This "holding memory" (Falk, 2002. p.120) is an incredible feature of the work. I know from my own practice that clients do remember their images, even when many other details of their lives have

been forgotten. I wondered at the start of this study if this was also a phenomenon in the other arts therapies. It appears to be the case.

There has been no clear identification in the literature, until this study, of the objective of the work. Writers have focused on the aims of individual pieces of work/research (Harlan, 1990; Waller, 2002; Aldridge, 2000; Marion-Violets, 2004). The aims identified by the arts therapists in this study were the same across the disciplines and in the literature review. One exception was the notion of *skill acquisition* that was mentioned by Heather (AT). I could find no previous literature that highlighted this as an aim of the work. One reason might be that, like the idea of *hope* (mentioned by Stella, DMT), there is an assumption within the profession and in society in general that older people with dementia cannot learn. This study has highlighted that, based on the arts therapists views, the person can learn, can acquire new skills.

Power dynamics

Power dynamics were evident in the care settings. One reason for this was that the arts therapists were *pioneers*. This study is testament to the pioneering spirit of the adventurers who have walked the rocky road. Pioneering is a complex business. As a pioneer you must create a path, starting from scratch by cutting down the long grass stretched in front of you. The way ahead is uncertain, there are many unseen holes and tufts of earth to unsteady you. The descriptive map suggested that the pioneers were working in community residential and hospital settings, and to a lesser extent in community day units.

As a result of the arts therapists being pioneers, their medical/care staff colleagues had limited or often no prior knowledge of their work practice before they worked in the setting. This lack of prior understanding impacted heavily on both parties and caused much of the ensuing set-up and interdisciplinary difficulties outlined in this study. The arts therapists were working in ways that sat outside 'normal' medical/care working practice. They were not working within the context of a particular medical or care model (although more aligned to the person-centred care model espoused by Kitwood (1997) than the biomedical model) and as such, settings were, naturally, often unprepared in respect of providing and maintaining a

confidential therapy space. The reason for this was that the majority of medical and/or care staff did not understand why their new arts therapist wanted to work in a private space. Agnes and Mary, two care staff that I interviewed thought they were getting another activity officer.

The literature review and the descriptive map illustrate that there are different power dynamics in operation in the dementia care setting. One of the most pervasive is the loss of power experienced by the older person who has dementia (Cheston and Bender, 1999). As already indicated, one of the first things that happens to the person on entering the care setting is that he/she, without support, becomes reliant on his/her carer, trapped in a cycle of dependency which subjugates him/her into what Burgess (1960, p.10) terms the “role-less role”. I reflected that, interestingly, this situation is mirrored to some extent by the arts therapist pioneers who also, initially, are totally reliant on their clients’ carers and the care team to help them get established in the care setting. Janice’s (DMT) story of the window cleaner, acting as a translator between the care staff and herself, illustrates this point.

I sensed a shared feeling among the arts therapists that they like their clients often went unheard in the setting, they were not fully part of the dominant culture, although, unlike their clients, they had the choice between *being unheard* or *staying unheard*.

In terms of being unheard when I analysed the interview transcripts I noticed that sometimes the words the arts therapists used to describe their work mirrored the language they used to discuss the psychological and emotional issues that impacted upon their clients. I was surprised to see that these words (Table 26) related not to the challenges the arts therapist faced working with a complex client group but rather to the challenges they faced in their relationship with their colleagues in the practice setting.

Table 26 - Unheard: Mirroring of Emotions	
Older Person	Arts Therapists
Personal isolation Loss Depression Feeling disconnected Communication difficulties Need to be accepted	Professional isolation Not knowing Distress Lack of understanding of role Communication difficulties Struggle to gain acceptance

Many of the challenges related to the arts therapists' experience of working in care settings where there was a strong power dynamic in operation. The collective nature of the dementia care setting, particularly residential and hospital care, can create an entrenched culture (e.g. working within fixed rules and routines) which some arts therapists initially found difficult to penetrate. For example, Orla (MT) and Rebecca (MT) were reliant on the diary system on the wards to remind staff to bring their clients to the music therapy session. They were not in a position to change this procedure to say a more 'on the spot' type referral. It seemed that they were not in a position to change any of the procedures except for their own which they had to constantly re-shape in order to fit in with the culture of the setting. I had a sense that both arts therapists felt powerless against the dominant care culture. Powerlessness can be such a pervasive emotion that I wondered to what extent Orla (MT) and Rebecca (MT) had actually managed to challenge this dominant culture? Had they, for example, suggested a different type of referral system to their NHS colleagues? A similar question could be asked about how arts therapists negotiated their therapy space within the settings where they worked. From the descriptive map it appears that it was really pot-luck where the arts therapists ended up working; bedroom, lounge or a multi-function room. Of course the reason for this was that many of the settings were not equipped with their own purpose built therapy spaces, these had to be created out of existing spaces (Kamar, 1997; Moss, 2003; Violets-Gibson, 2004; Harrow, 2005). But I did wonder how often the arts therapist actually challenged the unit manager about the therapy space he/she was given.

I also wondered if arts therapists challenged the medical/care staffs' assumptions about arts therapy work. It seemed to me that it was too easy for the doctor treating

Heather's (AT) client to dismiss the work that she was doing and to ignore the wishes of her client's family that AT should continue. One reason, I believe, was because Heather (AT) was the only art therapist in her care setting and was not supported by a team of other arts therapist who could testify to the value of the work. Another reason was that she volunteered to work with her client when he was moved from day into hospital care. I wondered if her presence as a volunteer art therapist somehow devalued her professional status as a qualified art therapist in the eyes of the doctor. Volunteering is a noble act but when a profession is trying establish itself there is surely the potential for such an act to do more damage than good? Practitioners from outside the field might misunderstand the professional nature of the discipline and think that it was easy to replace a paid professional with a volunteer.

The descriptive map highlighted many examples of medical/care staffs' lack of understanding about how arts therapists worked in practice. For example, Orla's (MT) employers did not understand that professional supervision was a requirement of her MT work. She felt that she was being unheard by her NHS employers because they would not pay for her supervision. Orla's (MT) situation made me wonder about how much input she had when she initially negotiated her contract. Was this issue not raised then? This made me think that perhaps the struggle to secure permanent work meant that arts therapists had the tendency to rush into accepting permanent posts without scrutinising the finer details of their contract. A lack of clarity between employee and employer clearly may lead to misunderstandings about the professional requirements of the employee.

The issue of not being heard was particularly acute for sessional arts therapists For example, Jenny (AT) was not given time before she started the work to get to know and inform the staff team about her practice. She like other art therapists in the same situation was expected *to hit the ground running*. Jenny (AT) was working across five different care settings offering one weekly session in each. I reflected that working in such a way did not give her much opportunity to establish vital support networks with other members of the staff team. The consequence of this was that the staff team were unfamiliar with her working practice. I wondered how Jenny (AT) sustained this type of work. The answer I think lies in the relationship she was having with her clients. Falk's (2002, p.120) observation that

through image making the client moves from an, “exterior space that (is) perceived as muddled and full of dread, to an interior space, over which they (have) some sense of control.” I wondered if this also applied to the arts therapists in the sense that he/she could tolerate all the initial set-up difficulties and general misunderstanding about his/her role because he/she felt sustained by the client relationship.

Despite finding sustenance in the therapy work itself the descriptive map illustrated that the part-time and sessional arts therapists found it difficult to address misunderstandings about aims of their work because their work pattern meant that they did not always have regular contact with their colleagues. This situation only served to increase the arts therapists’ feelings of professional isolation. In future employers need to plan more for the inclusion of the arts therapist into the multi-disciplinary team. In general much more planning needs to take place before the arts therapist begins working in the dementia care setting.

The previous section highlighted the theme *being unheard.* Exploring this interpretation further I was interested to consider how many of the arts therapists were *staying unheard*. I wondered, for example, if the arts therapists were proactive in *staying unheard or* had overcome the initial clash of culture to find some common ground with their colleagues. Sarah (DMT) had joined forces with her OT colleagues and together they had managed to secure a therapy space they could use for sessions. Susan (DT) had begun to work fortnightly with her clients at the request of her employer. This is not common practice, but for Susan this was the only way she could see all the clients referred to her. I wondered about the continuity of the work and how clients with dementia could sustain any memory of the sessions when these occurred fortnightly. Susan (DT) felt it was important to offer the person some input rather than none at all. This made me reflect on how complex it was for lone arts therapist to sustain regular ‘therapeutic’ contact with their clients. Despite this difficulty something did sustain Susan’s (DT) clients because they continued to attend her sessions fortnightly and they did engage in DT with her. The combination of the therapeutic relationship and the art form were key to sustaining the client’s motivation to attend the sessions.

An interesting finding from the descriptive map was that a group of AT, DT and DMT therapists were working with the whole community in their respective care settings. They were working in ways that were more aligned to the community or social theatre model (Powell, 2004; Jennings, 2005; Wood, 2007) rather than any specific psychotherapeutic model. For me this was an interesting example of arts therapists practising in the 'real world'. They had adapted their practice to incorporate both open (community wide) and closed therapy work. I wondered if this was the way forward for all arts therapists working with this client group If so, much more discussion is required as to how this model of practice could be integrated into current arts therapy practice.

I think the findings raise some questions about what the arts therapists could do to stop staying unheard in their settings. One could argue that arts therapists need to be more proactive in promoting their work. Perhaps to offer workshops to their medical/care staff colleagues as Kim (AT) and Bernard (DT) did in their settings. Time and funding are always a factor but without one's colleagues onside it is difficult to establish a supportive network, particularly if one comes from a different discipline. I think that arts therapists need to learn more about the routines of their respective settings. The descriptive map suggested that the arts therapists were not interested in the type of dementia their clients were labelled with. They had some knowledge of the different stages the person moved through but again this was not something that pre-occupied their thoughts (although clearly it did have some impact on the work) because they wanted to offer an inclusive rather than exclusive service. Only Kate (DMT) and Bernard (DT) commented that it would be difficult to work with a person experiencing advanced dementia. Perhaps by increasing their biomedical knowledge it might help the arts therapists to understand the care needs, and as a consequence the reasons why care staff need to interrupt a session to give a person medication at a set time. Freya's (DMT) statement that she did not like labels (it could be argued that arts therapist are caught up in their own label culture, one that is framed in its own language) is understandable but learning about the different types of dementia does not mean that arts therapists have to accept the label, rather they become aware of another perspective. Johnson et al. (1992) and Waller and Sheppard (2006) make the point that arts therapists need to make themselves aware of their clients medical condition. This is an important part of professional practice.

Adopting and adapting procedures

There was a lot of adopting and adapting of referral, assessment and evaluation procedures going on by the arts therapists. These were often adopted from mainstream arts therapy practice and adapted to meet the needs of this client group.

The standard referral process outlined in the literature by Coaten (2001) is of the preparatory work that goes on between arts therapist and care staff in order to identify potential clients for therapy. The study has highlighted that this mainstream arts therapy procedure does happen but that there is also a more immediate *on the spot referral* in operation, particularly in the community residential and day settings. Crimmens and Kelly (1994) and Powell (2006) talk of arriving at their respective settings, speaking with potential clients and inviting them to the arts therapy session. The writers, however, give no real reason why this type of *on the spot referral* was used. In this study Laura (DMT) gives one reason when she states that her clients' anxiety levels were raised if they were told too early that something new, like the DMT session was happening. The findings highlight there were a number of external factors that contributed to the need for the *on the spot referral,* such as difficulty for arts therapists to plan ahead because their client might not be feeling well or he/she might have an appointment that day. In this instance, *on the spot* referrals afforded the arts therapists the opportunity to offer an inclusive and flexible arts therapy service. However, in saying this it is important to state that most group and individual work involved the same client(s). This is illustrated by the fact that the arts therapists talked about the ongoing relationship they had with their clients.

The descriptive map suggests that the standard DMT and DT preference for working with clients primarily in a group did not always apply in this context. All the arts therapists (DMT and DT included) recognised that individual work was the preference when working with a person experiencing the later stages of dementia and that more of a mix of individual and group work was appropriate for clients experiencing early to middle stages of dementia. This concurs with Vink's (2000) findings from her study of music therapists in the Netherlands. Like them the arts therapists in this study generally preferred offering both individual and group work

but the reality was that they, particularly sessional arts therapists, were at the behest of their employers in terms of the type of work they did. Cash-strapped care settings, as Janice put it, needed “bums on seats” to justify the existence of the service. This was evidenced by Grace’s (DMT) desire to do more individual work but her employer’s preference was for her to do more group work.

An issue in terms of group work relates to the compatibility of the group. The stage of dementia experienced by the person was an important issue in this regard. Stage theories are not popular because they are used to categorise people (Kitwood, 1997; Benson, 2003) but perhaps not considering the stage of dementia experienced by the person has an equally detrimental effect in terms of group work. Lumping clients together in one group without careful planning is not good practice. Grossman et al. (1986) remark on the dehumanising effect of creating a group of people who are at different stages of dementia. This issue must be given more consideration by employers when they request group work.

There was a lot of adopting and adapting going on in terms of the duration of the arts therapy session. Some sessions would be a constant one to two hours (group session) in duration, while other sessions may change week on week depending on the client(s) ability to sustain concentration. However, it is interesting to reflect in the midst of all this adopting and adapting of procedures that the frequency of the sessions remained the same. Apart from Susan’s (DT) fortnightly sessions with clients, all the remaining art therapy sessions took place each week, at the same time and usually in the same place. There was no evidence in UK arts therapy practice of Germany-based writers Ridder and Aldridge’s (2005) suggestion that client(s) received four to five shorter sessions per week rather than one long session, and of the American writer Harlan’s (1990) advice that clients participate in two or three sessions per week. The reason why this did not happen in the UK, I believe was primarily financial.

All the arts therapists were reliant on medical/care staff to help bring frail and wheelchair bound clients to the session. In DMT and DT staff would participate, helping for example in a DMT session to engage clients with restricted movement patterns. Although less common in AT and MT the inclusion of a member of staff in these sessions was reported by Pamela (AT), Heather (AT) and Kim (AT) and by

Orla (MT). In terms of the literature there has been little widespread discussion about the employment of staff help in the arts therapy session. Coaten (2001) wrote about care staff joining him in his DMT session and about the skills such as non-verbal communication and empathy that he felt they could learn from the session. Violets-Gibson (2002, 2004) and Kowarzik (2005) wrote about their joint work on the LMC project, the aims of which were partly to train care staff in person-centred movement techniques. Other writing by Powell (2004) and Wood (1997) focused on a community music therapy model where everyone in the setting became involved in the music therapy session. However, this is distinct from a staff helper coming into a closed group session; no literature appears to discuss this type of input. This study has highlighted for the first time that the staff helper/arts therapist relationships, when planned, could be very valuable for all parties. Successful partnerships had the potential of helping the arts therapist manage the group, so providing him/her with an important connection with the staff team and with that an increased understanding of the setting dynamics. For the staff member, too, the possibility of participating in the arts therapy session provided him/her with an opportunity to learn a new way of working with his/her clients

It was clear that not all staff helper/arts therapist relationships were supportive. When time was not taken by the setting manager to assign a willing and interested member of staff to the arts therapy session, someone who could commit regularly to the sessions, then this partnership was more problematic. The example of the staff helper yawning and looking bored in one session that I attended was not going to engage an already de-motivated group of people. Moreover, assigning care staff in an ad hoc manner to the arts therapy session disrupts the work done by the arts therapist and prevents him/her from establishing a stable and constant therapeutic relationship. As more awareness grows of how arts therapists work with people who have dementia, more consideration must be given to which member of the staff team works in session with the arts therapist.

The arts therapists employed predominantly informal assessment procedures; intuitive procedures that primarily involved them observing and recording their clients participation in the session. These findings seem to concur with Towse's (1995) descriptions of the procedures that she employed. This suggests that in the thirteen years since Towse (1995) wrote her article there have been no

developments in terms of specific assessment procedures for this client group. As the descriptive map highlighted, assessment was a 'hot topic' for the arts therapists. Many felt that the informal procedures they employed lacked the complexity of the more formal assessment procedures they saw their non-arts therapy colleagues use. However, to my mind, this informal way of assessing their clients actually required the arts therapists to maintain a sophisticated ongoing understanding of the changing needs and responses of their clients to the arts therapy sessions.

I found it interesting that only the dramatherapists adapted formal assessment procedures from mainstream DT and occupational therapy practice. The reason for this was that they were the most eclectic in terms of adopting and adapting non-arts therapy procedures. They were more likely to borrow procedures and techniques from other disciplines than AT, MT and DMT participants.

In terms of the other arts therapists, I was interested why they had not adopted formal assessment procedures like the DTs. The taster arts therapy sessions that they used could be considered a type of formal assessment; however these sessions were person specific and therefore difficult to standardise. It seemed like there was no real desire from AT, MT and DMT participants to develop a set of assessment procedures. But is this really true? Some of the arts therapists were clearly influenced by the formal assessment procedures employed in their respective care settings (e.g. NHS). If this was the case then perhaps it was more about them not being able to articulate how they adapted these procedures into their practice? There was a lack of clarity with regards to this issue; formal assessment procedures underpin Laban Movement Analysis (1975) and Kestenberg Movement Profile (1999) two of the DMT theoretical influences cited by Sarah (DMT). Despite the strong assessment element in both these models Sarah (DMT) did not refer to them when I asked her about assessment procedures she employed with her clients. This made me wonder if she was intuitively using elements from these models in her work or that they could not be directly applied to DMT work with this client group.

The ongoing evaluation procedures, like the assessment procedures, were largely informal. In the literature I found that only Odell-Miller (1995) and Coaten (2001) commented on their ongoing procedures, involving observing, discussing with

medical/care staff and writing reports. The need for flexibility seemed to be the key reason for the use of informal evaluation procedures.

The descriptive map highlighted that the arts therapists were adopting and adapting theories. They employed an *integrative/eclectic* theoretical approach (Figure 2). A mix of *psychotherapeutic*, *artistic* and *other* theories influenced their practice. The employment of an integrative/eclectic approach is in line with Karkou's (1998) findings from her study of mainstream arts therapy theoretical influences and Vink's (2002) study of music therapists in the Netherlands.

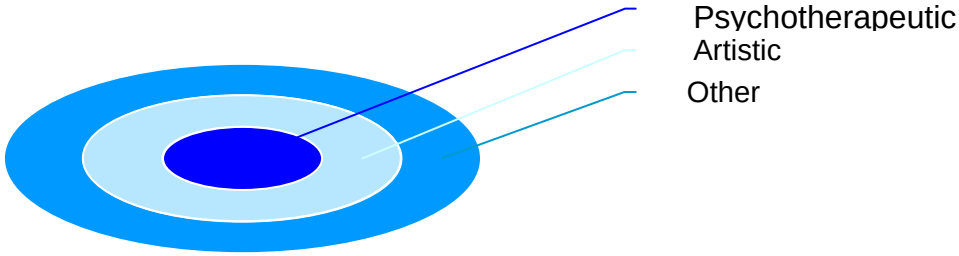


Figure 2 – Integrative/Eclectic Influences

What this study brings to the theoretical debate is a new understanding of how the different theoretical elements within the integrative/eclectic approach are employed by the arts therapists. For example, in session MT, DMT and DT participants integrated person-centred and artistic theories. Other arts therapists (primarily art therapists but some arts therapists) used person-centred and artistic theories in session and psychodynamic theories outside the session in their reflective notes and in supervision. They did this in order to gain a deeper understanding of the dynamics of the therapeutic relationship. There has been no clear understanding, until this study, of how the arts therapists integrated these different theoretical influences. I explore these ideas further below.

In terms of the psychotherapeutic element in the overall integrative/eclectic approach, the study revealed that in the session arts therapists from across the four disciplines primarily employed a person-centred approach, drawing on the theories of Rogers (1951); Kitwood, (1997), Prouty's (2001) work on pre-therapy. It is important to note that the Prouty et al's (2001) work has not previously been mentioned in the arts therapy and dementia literature. It was interesting to see that

the arts therapists were moving away from some of the mainstream theoreticians to find client group specific examples of their work.

The predominance of person-centred ways of working in sessions was of particular interest for me in terms of the art therapists who in mainstream practice primarily work in a more psychodynamic way, for example offering a more non-directive type intervention. This study highlighted that art therapists like Pamela (AT), Jenny (AT) and Jasmin (AT) had begun to question how their psychodynamic training fitted into their current dementia work. The reason why these participants questioned the appropriateness of psychodynamic work with people who have dementia (moving the debate beyond Cheston and Bender's (1999) claim that it was professional snobbery) was because they could not envisage how theories developed for adults with functional mental health problems could be applied to clients with an organic illness. I think this point was evidenced by Pamela's (AT) statement about not working psychodynamically while at the same time she acknowledged the importance of the transference relationship.

On face value Pamela's (AT) words are inconsistent because on the one hand she is rejecting psychodynamic thinking while on the other she acknowledges its importance in respect of understanding the transference dynamic of the mother-daughter relationship. However, I think that Pamela's (AT) statement gives a sense of the complexity that psychodynamically trained arts therapists face when trying to fit mainstream theories into dementia specific practice. They do not know how confused their clients are going to be during the session. They do not know how much directive or non-directive input the client will tolerate (Burns, 2007). So much of the work is about the not knowing. Perhaps this was one of the reasons why Waller and Sheppard (2006) wrote of the need for art therapists to adapt psychodynamic theory when working with clients with dementia but the writers were unable to suggest how this theory should be adapted. The descriptive map highlighted that several art therapists spoke of psychodynamic theories influencing their work. However, on closer analysis of their statements it was clear that they were employing psychodynamic theories to help them process the therapeutic relationship, to think about the transference and counter-transference dynamic (Wilks and Byers, 1996), to consider Jung's (1978) concept of individuation (1978)

and Bowlby's (1997) thoughts on attachment theory, but significantly this was being done outside the session, in their session notes or in supervision.

In terms of directive and non-directive work Thomas' (AT) sessions illustrated that he was unable to work in a purely psychodynamic way. He had to include directive elements into his sessions. Kim (AT) similarly spoke of not liking directive work but she recognised that her clients from time to time benefited from this more structured approach. The underlying message for me was that these art therapists were anxious about moving away from non-directive ways of working; this went against the grain in terms of how they had been trained. This topic warrants a lot more discussion. I think it would be useful to consider the level of psychodynamic psychotherapy that art(s) therapists are working at with their clients who have dementia. Wald (1989, p.215) reminds us that art(s) therapy work with this client group is "supportive" rather than "curative". At the supportive therapy level the therapist works on ego strengthening, does not confront but supports the person and is more interactive (e.g. directive) in the session. If arts therapists were more assured about the level of psychodynamic psychotherapy therapy they worked at with their clients then this would help to reduce their anxiety and moreover provide a clear rationale for incorporating directive and non-directive elements into the work. I believe this will happen as the field begins to develop its own identity.

Some of the music therapists similarly talked of using more pre-composed music, rather than just relying on their client's ability to engage solely in an improvised session. This issue confirms Darnley-Smith (2002, 2003) and Towse's (1995) belief that clients with dementia do benefit from a mix of improvised and pre-composed music. This study has highlighted that the majority of music therapists, like the art therapists, were integrating directive and non-directive elements in their sessions. Interestingly, this did not appear to be such an issue for the DMT and DT participants who moved more easily between structured and unstructured activities. The literature from these disciplines suggests that mediating between different elements in the session is standard practice (Batson, 1998; Lev-Aladgem, 2000; Violets-Gibson; 2000; Hill, 2006)

The descriptive map highlighted that in terms of artistic and other discipline theoretical influences, art therapists were the practitioners least influenced by these

principles. This fits with the trend in the wider field identified by Karkou (1998). Historically, AT has been underpinned by psychodynamic rather than artistic or other theories. MT, DMT and DT are more influenced by artistic and other theories. In MT Aldridge's (2000) writing specifically on people with dementia influenced Ben's (MT) work. In terms of the mainstream MT theoreticians such as Alvin (1975) and Nordoff and Robbins (1971, 1977) the concept of improvisation predominated. The dramatherapists integrated aspects of the theatre model (Jennings and Mitchell, 1992), the six-part story method (Lahad, 1992) the play model (Axline's, 1990) into their practice. In DMT the mainstream theories of Laban (1975) and Kestenberg Movement Profile (1999) influenced practitioners. Laura (DMT) had trained in Margaret Morris Movement (MMM) (2004), structured around physical dance techniques, and this did inform her thinking about her clients' movement patterns. Similarly, Freya (DMT) talked of adapting elements, such as her role as witness, from Authentic Movement (1999). Elements from all the mainstream models were adopted and adapted to suit the individual arts therapist's practice. I think the need to employ an integrative/eclectic approach was prevalent particularly in the residential and hospital settings where the arts therapist worked with clients who were at different stages of the disease. From a wider perspective adopting a range of integrative/eclectic theories was fundamentally important for the field because the arts were viewed as fluid not static entities. If the arts therapists offered too rigid an approach this could stifle the client's potential for creativity and emotional release.

An interesting observation was that the arts therapists interviewed generally did not discuss the influence of writers from the arts therapies and older people/dementia literature. For example, David Aldridge (1993, 1994, 1995, 2000), arguably the most prolific European writer in MT and the dementia field, was cited only by Ben (MT). Orla (MT) was interested in Darnley Smith's (2002, 2003) writing on integrating directive and non-directive elements into MT sessions. Similarly, none of the dramatherapists mentioned the work of Gordon Langley (1983), and Dorothy Langley (1987). One reason for this could be linked to the individual arts therapist's own theoretical orientation. The majority of the writers cited in this study were from outside the UK and their assumption could be that practice is different elsewhere. For example, a behavioural type model informs US AT practice (Wald, 1989; Harlan,1990). Another reason could be linked to the fact that most of the arts

therapists work on their own. In such a situation there is an absence of colleagues to share new knowledge with and discuss ideas related to arts therapy practice. This point has particular relevance for the field and for this study in terms of how specific practice knowledge is disseminated.

The findings highlighted that a group of other discipline theories were woven into the integrative/eclectic model employed by the arts therapists. For example, Pamela (AT) had become interested in coma therapy (1988). She employed some of the techniques from coma therapy in her AT sessions with clients who were in the later stages of dementia. I reflected that employing such a model raised many questions about the nature of end of life working and the type of therapy work arts therapists were engaged in. Moreover, I wondered if Pamela's (AT) interest in coma therapy illustrated her uncertainly about the applicability of AT for clients with advanced dementia? Pamela's (AT) clients were not engaging in sessions in the traditional sense (e.g. using art materials to create images) they required an approach that facilitated more interaction with her. It seemed to me that Pamela's (AT) therapeutic rather than her artistic skill was the most valuable for these clients. But was it AT? I think this depends on your definition of AT. Is the work primarily therapeutic or primarily artistic? From my perspective Pamela (AT) was engaged in AT because she incorporated all the principles of supportive therapy (e.g. holding, containing and engaging with the client). However, Bernard (DT) and Kate (DMT) would disagree with me because her client was no longer able to engage in the art form. Unlike Pamela (AT) the starting point for Bernard (DT) and Kate (DMT) was always the art form. The different views of these therapists underpin some of the disciplinary distinctions identified in this study.

The descriptive map illustrated that the music therapists were influenced by a number of other theories and theoreticians among these were Stern (1974), Trevarthen (1979), Csikszentmihalyi (1990) and Damasio (2000) who all came from mainstream practice. In terms of DMT Grace (DMT) was influenced by Montagus' (1971) theories on touch. She was the first dance movement therapist to identify a theoretician in respect of the topic of touch in therapy work. The other DMT participants and writers in the field discuss therapeutic touch in general terms. Samberg (1988, p.234) for example, talks of touch as a "primary means of communication."

It was interesting to reflect on why the dramatherapists did not mention any *other* theories and theoreticians. Dramatherapists were adept at adapting mainstream principles from DT practice into their dementia work. The art form lies at the heart of DT practice and there are a number of DT authors writing generically about the art form and its application to a number of different client groups. This would suggest that art form techniques (rather than psychological principles) are perhaps more easily adapted from mainstream into dementia specific practice.

Emergent practice

The reason why the arts therapists were adapting procedures, employing an integrative/eclectic theoretical approach, was because typically the arts therapists and their clients were engaged in a *temporal* intervention. Mainstream arts therapy work with cognitively cognisant clients is longitudinal, built upon week on week. The findings in this study illustrate that when working with clients who have dementia the arts therapists are working within a session structure that is more temporal in nature.

In this type of structure the person is orientated at the beginning and end of each new session. The descriptive map illustrated that there was a two-phase beginning to the session. In phase one, *the check in,* the person would be welcomed and orientated to the space and people within the space via conversational and observational comments. In phase two the person would be orientated to the art forms. The central part of the session was about connecting the person with the art form and helping him/her to use it as a means of *expressing.* In the central part of the session the arts therapists were employing both directive and non-directive techniques. The findings highlighted that this part of the session was improvisatory in the sense that the client(s) and arts therapist worked together in ways that were often unique to their relationship and to the particular discipline. The final part of the session was about grounding the person in the 'here and now and taking time to reflect on the process (Table 27).

Table 27 – Temporal Session Structure		
Structure	Method	Process
Beginning		
Phase One	Check-In	Orientating
Phase Two	Art Form Warm-Up	(Re-) Engaging
Central Part	Main Activity	Connecting
		Expressing
End		
Phase One	Art Form Close	Grounding/Reflecting
Phase Two	Goodbye	

Looking at the session structure it becomes evident that these sessions were temporal, single units containing a beginning, middle and end. There is limited discussion in the literature in respect of the session structure. Writers who discuss the structure of their sessions write primarily about either a very general structure (Odell-Miller, 1995) or a very specific one like Ridder and Aldridge's (1995) four-stage structure, which was employed with a specific client but which has not been adopted into the MT profession. This study offers for the first time a way of understanding how clients who have dementia are supported by the session structure to engage with the art form. The study illustrated that although the arts therapists were using different art forms, a similar session structure was adopted by most of the arts therapists undertaking closed session work. Of course, in saying that, it is important to acknowledge that not all clients progress through every part of the session structure each week. One person might only be able to concentrate for ten minutes and so would engage with phase one and two at the beginning of the session and not move on to the main activity. The need for flexibility and the ability to move with the person's changing mood state and capability has contributed to the development of a temporal session structure and has given rise to some interesting *multiple methods* being used in practice.

Many of the arts therapists were using methods employed in mainstream AT, MT, DMT and DT practice and adapting these to suit this client group. In her PhD study,

Karkou (1998, p.223) noted that in mainstream arts therapy practice there was a tendency for the arts therapies "to be a highly individual modality." In this study there is some suggestion that art therapists were using multiple methods in their sessions and that art therapists in particular had borrowed from other art forms or other creative disciplines to inform their practice. For example, Pamela (AT) employed a technique from DMT, a physical warm-up using a balloon. This was similar to the balloon and stick game that Janice (DMT) used at the beginning of her sessions. Jasmin (AT) used a word game. In the central part of the session when the arts therapist and his/her client(s) tended to work in a highly individual way there was some evidence of participants using multiple methods. For example, Jenny's (AT) group spent some sessions writing down and recording memories, techniques from reminiscence therapy (Butler,1963) while other sessions were more AT orientated in that the group spent time working on group images. The dramatherapists in particular, it seemed to me, engaged naturally in the use of multiple methods. For example, Beatrice (DT) encouraged clients to visit the rooms of other group participants in order to get a sense of each other, writing down a story from the person's life, with another client she renovated furniture. Bernard (DT) used reminiscence props and soap operas as a starting point for his sessions. Grace (DMT) created and used reminiscence boxes, a technique from reminiscence therapy. Sitting apart from this trend were the music therapists who did not use multi methods in their work. One possible reason for this was that the music therapists' professional life, right from undergraduate degree to postgraduate training and subsequent career, was in music. Within the MT literature the debates centre on musical contexts (Pollack and Namazi, 1992; Clair, 2000; Ridder and Aldridge, 2005). It seemed that music therapists are never exposed to other ways of working and so have built up a repertoire that is based purely around the art form. In this respect it is interesting to consider if music *holds* the client more than the other art forms.

The previous paragraph illustrated that some arts therapists were using multi methods. If not employing multiple methods the arts therapists were, to some extent, adapting their practice to fit with the needs of their clients. This suggests, perhaps, that the arts therapists are engaged in an intervention that is not fixed or permanent. This raises questions about the nature of the therapeutic relationship. For example, what is its purpose? How is it sustained? In addressing the first

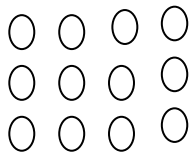
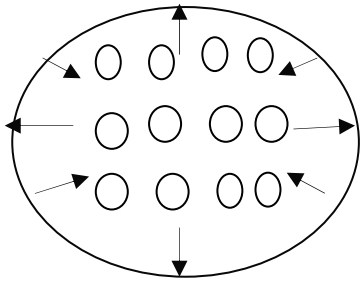
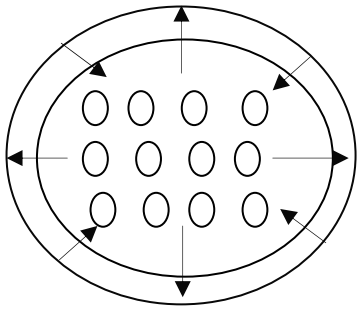
question the study concurs that the client therapist relationship provides the person with dementia with a different type of relationship (Kitwood, 1997), one that is removed from the task or activity orientated relationship that frames much of the interaction in the care setting. In the arts therapy session there is a coming together to work directively and non-directively. The person is offered the potential of containment and autonomy, of temporality and constancy. The person is supported but also given the opportunity, if he/she wishes to make choices in respect of the art materials, instruments, props that are used, the way they are used and what is created. The diversity of the work undertaken in the central part of the session underlines the point that sessions are very much tailored towards the individual/group.

The therapeutic relationship is sustained because it is constant. The arts therapists' preoccupation with boundaries and creating a confidential space and regular session help to create a state of constancy where the client and therapist get to spend quality time with each other. The constancy of such a familiar relationship is often missing from the person's life and therefore is one that may be remembered by the person. The notion of constancy of the therapeutic relationship is not new within the arts therapy literature. Miller (1982) and Wilks and Byers (1995), to name just a few, have written of its importance. The notion of constancy and temporality sitting side by side is new. Sessions may have a temporal quality but they are seldom one-off encounters between client(s) and therapist. All the arts therapists in this study have spoken about working with their clients over a period of time. Weekly sessions with the same therapist (and group) in the same space facilitated the development of a supportive and trusting relationship. Tyler (2002, p.68) observed that art therapy offered the person "an opportunity to organise their experience in their own way without expectation from others." This freeing of the person from the routine of the care setting and placing him/her in a situation where he/she has the freedom to make choices was an important way of validating the person (Susan DT). When a person feels validated he/she is more likely to engage.

The second element that brought constancy to the person was the art form. It is clear from the study that all the arts therapists believed that sustained engagement in the art form afforded their clients with a type of constancy that had the potential to structure him/her. Kate (DMT) gives the example of her client being able to

dance once more with her husband. The literature has spoken of this notion of the art form offering the person some type of reconnecting or restructuring: in the UK AT and DT literature (Miller,1984; Langley, 1987; Falk , 2002; Tyler, 2002) and to a larger extent in the international MT (Aldridge, 2000; Tomanio, 2000; Munk-Madsen, 2001) and DMT (Samberg et al. 1988) literature. For example, Aldridge (2000) makes reference to how music can scaffold a time structure for the person, one that stimulates the person's memory and ability to perform in the present. In AT UK literature, Falk (2002, p.120) explores this notion of "holding memory", that week on week clients could remember the symbolic images they made because these were created in an interior rather than exterior space over which the person had some sense of control. This study illustrates how the constancy of the art form (the exterior) and the relationship (the interior) bridged the temporal structure of the weekly session and allowed the person to connect to a sense of self, other people and the environment. Table 28 illustrates how the temporal arts therapy session is support by the constant dynamic of the therapeutic relationship and the art form.

Table 28 – Temporal and Constant Dynamic in the Arts Therapy Session

Temporal Sessions	Supported by the constancy of the therapeutic relationship	Supported by the therapeutic relationship and the art form
		

The person may need to be orientated at the beginning of each session and re-engaged in the art materials, instruments or props but once that re-acquaintance has happened the person usually finds, through the art form and relationship, a present time stimulus that sustains him/her in the session and beyond. This is what separates the arts therapies from the less formal arts activities advocated by Killick and Allen (1999). Arts activities are product-orientated, one-off directive

interventions that do not take account of the ongoing process. The arts therapies or the "formal therapies", as Killick and Alan (1999) called them, mediate between the temporal and constant dynamic. In doing this they seem to offer more potential for connecting the person to his/her sense of self, other people and the environment. It could be argued that mediating between the temporal and constant dynamic mirrors the person's capacity to move in and out of different realities.

Life lessons

Tyler (2002) talked about society viewing older people as less attractive than younger people. Smith (2004) observed that health services for older people were "Cinderella" services, the implication being that health service workers, like the rest of society, do not prioritise the needs of older people. Why? The literature has illustrated that there is an assumption in Western culture that when you are old and ill you have nothing left to offer the younger generation (Towse, 1995; Tyler, 2002). It was interesting to reflect on what the arts therapists had learnt from their clients. Claire (MT) and Susan (DT) spoke of learning what it was like to be a human being. For Susan (DT) the work had encouraged her to think existentially about how much a person exists when his/her mind goes. Susan (DT) commented that she had learnt to alter how she perceived her clients spoken language. Instead of regarding their communication as fragmented and disjointed she had begun to consider the wisdom behind the words. In the literature review Casson (1994) (also written about by Killick, 2000) considered the metaphorical meaning behind the spoken words of his clients with dementia as important. He, like Susan (DT), had found meaning in what his clients said. Listening carefully to what lay behind the words could help Susan (DT) and Casson (1994) to get a sense of how they were feeling.

Through the work the arts therapists confronted many assumptions and preconceived ideas they had about how it was to live with dementia. Stella (DMT), for example, had learnt that the work could engender feelings of "hope" within her; by this she meant that the person's quality of life could be improved in some way. The words *hope* and *dementia* may seem a paradox but Stella's (DMT) thoughts hint at one of the great truths about end of life arts therapy work. People coming towards the end of their life are often the most alive and energised people to work with. They are motivated to keep the channels of communication open for as long

as possible. When verbal skills become difficult the person can find some refuge in non-verbal forms of communication.

The theme *life lessons* refers also to the new ways of working that the arts therapist had learnt. Traditional approaches from mainstream practice did underpin the arts therapists' practice but the findings in this study illustrate how the arts therapists had to adapt their a priori knowledge to suit the needs of their client who had dementia.

One important lesson the arts therapists learnt was *staying with the not knowing*. All arts therapy work has the potential to be fluid; every person, every creative act, every therapeutic relationship is different, however when working with a client with a progressive disease like dementia there is a degree of added uncertainty about the work. Dementia, as the biomedical (Whalley, 2001; Burns et al. 2000) and psychodynamic literature (Smyer and Qualls, 1999) illustrates, has the potential to fragment the person. Working with a person on a journey towards physical and mental decline can be overwhelming. From week to week there was a level of uncertainty about how the client would present in a session. The arts therapists often felt lost with the work, unsure how to support the person. Romy (AT) acknowledged that just trying to work out what was going on could be difficult because the person's logic fluctuated so much. Orla (MT) felt that the fragmented nature of the work made it difficult for her to create a continuum in the work. She was constantly asking herself, "What do I do with this?" The arts therapists often felt uncertain about the assumptions he/she was making about their client. The descriptive map highlighted that the arts therapists were constantly questioning their role and the value of the work. I felt that working with such a confused client group did have a tangible impact upon the work because it evoked feelings of uncertainty in the arts therapists. I think that the arts therapists, in particular the art and music therapists were trying to find *ways of knowing* by using more structured activities such as directed art and music exercises.

Much of the work, I reflected, was about the arts therapists trying to contain their anxieties as they stayed with the not knowing. Reinstein (2004) commented on the anxiety he felt when he first began to work with Mary and Betty, but how these subsided when he found out what his clients' preferences were. There is something to be learnt from Reinstein's (2004) experience. His anxieties were reduced when

he found the right method of working with Mary and Betty. This study has indicated that adopting and adapting known practice, experimenting with multiple methods is one way the arts therapist can *stay with the knowing* of working with his/her clients.

Study lessons

In concluding this section it is interesting to consider the lessons that have been learnt during the course of this research project. At its inception this study was concerned with creating a descriptive map of the shared and distinct patterns of practice. While creating the map, the study has also discovered the many preliminary issues that impede and/or promote arts therapy practice. Key among these are the difficulties that the arts therapists encounter in their role as pioneers, for example, just getting established in the setting, finding a therapy space, liaising with clients and medical/care staff. The frankness and honesty of the arts therapists from across the disciplines was very welcome. Many of the set-up difficulties are tacitly known about in the field but often not openly discussed. When promoting an emergent field, writers tend not to dwell on the difficulties encountered in everyday practice. This can be evidenced by the literature reviewed in this study, the focus of which has been on the efficacy of the arts therapies practice with this client group rather than the detailing of the underlying issues that arts therapists face on a day-to-day basis.

Chapter summary

In relation to the similarities and distinctions between arts therapists, the study points overwhelmingly to a reciprocity of shared experience among the arts therapists. Their experiences were similar in terms of getting their practice established in the care settings, working with colleagues and negotiating their role within the setting, the theories and some of the in-session methods they employed. In terms of in-session practice the arts therapists adopted similar procedures for referring, assessing and evaluating their clients. Their sessions were constructed around the same session structure. It appeared that often the need of the arts therapists to orientate their clients took precedence over disciplinary preferences for a specific type of session structure. Distinctions did emerge in terms of the background of the arts therapists. The music therapists, for example, had a

different pathway into the field than the other arts therapists. The dramatherapists did adopt more formal assessment procedures than the other arts therapists. In therapy work the methods employed by the arts therapists did indicate their disciplinary differences although interestingly even here multiple-methods were employed by the AT, DT and DMT participants.

Chapter Twelve - Conclusion

Overview

In this concluding chapter a summary is offered of the patterns of practice that have emerged from this study. The chapter includes a list of practice statements that will be of value to practising arts therapists. This is in line with NHS Quality Improvement Scotland's (2005) Best Practice Statement initiative and Thorne's (2008) request that research into the clinical phenomenon to be made available to practitioners in the field. The chapter concludes by offering recommendations for clinical practice and future research.

Patterns of practice: the rocky road

The arts therapists travelled on a *rocky road into the dementia field.* All the arts therapists (except music therapists) had undertaken a variety of degrees and worked in a number of different jobs prior to commencing their arts therapy training; this created a mosaic *of prior training and career.* Post arts therapy training they entered the field with *polarised motivations* about working with older people who have dementia. Initially they felt *culturally incompetent* (Spaniol, 1997) uncertain about the nature of the work and its potential benefits for this client group. However, once in the field the arts therapists became *culturally competent* as they recognised the value of the work. Having decided to work in this area the arts therapists often faced the prospect of *fluctuating employment* as they tried to secure part-time, short-term and sessional posts within NHS, voluntary and private sector care settings.

In general music therapists did enjoy more job security than the other arts therapists. They worked predominately in the NHS where more permanent part-time contracts were available. Moreover, some of music therapists were also employed by an MT trust that contracted them out to work in various care settings. A question asked in this study was how could therapists from AT, DMT and DT secure more permanent employment? Is there the possibility that similar AT, DMT and DT trusts could be established? Trusts rely on public funding and music

charities have proven to be very popular. Could AT, DMT and DT attract the same level of public support? Whatever the situation, there is a clear need for the professional associations representing AT, DMT and DT to directly target employers who provide permanent contracts.

Arts therapists reported feeling 'burnt out' and professionally isolated by the work and there were many practical reasons for these feelings. From a psychodynamic perspective it was interesting to consider if such feelings were also linked to the arts therapist's unconscious feelings about not being able to tolerate the death of his/her client and his/her feelings of hopelessness about not being able to 'cure' his/her client.

Statements of practice:

- *Arts therapists come from many different 'walks of life' and bring to their work with people who have dementia different perspectives and ways of working. This diversity mirrors the uniqueness of the therapeutic relationship and the individuality of the person who has dementia.*

- *Specialised training in working with the person who has dementia will enable and support the arts therapists to become 'culturally competent' when working with this client group. This is an area that needs to be explored further.*

- *Arts therapists work in day and residential NHS, voluntary sector and private care settings on a part-time permanent, short-term or sessional basis. More permanent posts are needed, particularly for AT, DMT and DT practitioners, in order to make better use of their contribution to the field. Job stability will prevent current 'burn out' and professional isolation and further support the needs of clients with dementia.*

Patterns of practice: needing to feel connected

The art therapists perceived that the person with dementia experiences a range of complex psychological and emotional issues that can leave him/her feeling disconnected from the world. The overall objective of the arts therapy session was to connect the person to a sense of self, other people and the environment in which he/she lived. This was achieved through engaging the person in a purposeful activity (where skill acquisition was possible) by providing supportive relational interaction with the therapist/group. The art form was used to structure the person and provide an important means of primarily non-verbal communication and expression. The arts therapists validated the person's experiences by encouraging the person to explore past memories (reminiscence) and make independent choices.

Statement of practice:

- *Participating in the arts therapies can help to connect clients with dementia to a sense of self, other people and the environment in which they live. The therapeutic relationship provides a secure, supportive and validating relationship. The art form acts as a purposeful and structuring activity that facilitates the person's verbal and non-verbal expressions.*

Patterns of practice: power dynamics

Power dynamics were evident in the care settings where the arts therapists worked. The majority of arts therapists were pioneers in terms of their work being unfamiliar to their medical/care colleagues and vice versa. This mutual lack of understanding led to initial set up difficulties for the arts therapists and left them feeling subjugated by the dominant care setting culture. The arts therapists felt that they were *being unheard* in terms of not being able to establish their own procedures and protocols (e.g. referral system) and in terms of their own professional requirements (e.g.

supervision). Some arts therapists contributed to this power dynamic by 'mudding the waters' (e.g. changing role from paid professional to volunteer in order to support a client when he/she moved setting) and also not addressing initial set up issues directly with their employers.

The study considered if the arts therapists interviewed were proactive in *staying unheard*. The study found that in general once the arts therapists were more established in the setting they began to work collaboratively with their medical/care staff colleagues. This was helped by the fact some arts therapists, for example, were integrating principles from a community/social model into their open group work. This meant that clients, carers and occasionally family members took part in the session and as such the arts therapist became a more familiar presence in the care setting.

Areas where arts therapists could be more proactive involve dedicating more time to keeping their colleagues abreast of the work they do. This could be done in the form of periodical workshops or presentations. Moreover, the arts therapists need to learn more about the medical and care models that underpin client care in the setting. In doing this they will gain valuable insight into the perspectives of their colleagues.

Statement of practice:

- *Arts therapists are often pioneers because they are the first from their discipline to work in the care setting. As pioneers their work is generally unfamiliar to medical/care staff team and vice versa. This lack of understanding of each other's role can lead to misunderstandings and feelings of disempowerment by the less dominant party (e.g. the arts therapist). Both parties need to make a concerted effort to take time to understand the protocols and procedures of the other, in doing this they will prevent some of the initial set up difficulties outlined in this study.*

Patterns of practice: adopting and adapting

Arts therapists were adopting and adapting procedures in order to meet the specific needs of their clients. For example, arts therapists working in residential and day care settings employed informal referral procedures (primarily involving discussions between art therapist, client and care staff). 'On the spot' referrals were common in voluntary, private and some NHS settings. This referral procedure involved the arts therapist personally inviting the client to the session each week rather than expecting he/she would automatically attend.

Medical/care staff brought frail and/or wheelchair bound clients to the arts therapy sessions. In some settings staff stayed in the sessions and helped the arts therapist. This generally happened in DMT and DT sessions less so in MT and AT. The relationship could be mutually supportive if properly planned (e.g. the staff helper was aware of the aims of the session) and he/she could attend the sessions regularly.

The arts therapists were not particularly interested in biomedical concepts such as the type or stage of dementia experienced by the person. However, the stage of dementia the person was experiencing did have some impact upon the work. The arts therapists shared a preference for doing group and individual work with clients experiencing the earlier to middle stages of dementia and one to one work with clients experiencing the later stages of the disease. However, due to economic factors group work predominated across the disciplines.

AT, MT, DMT participants used informal assessment procedures. These were intuitive procedures that relied on the arts therapist's observation of the client, his/her engagement with the art form and relational interaction with therapist/clients. Formal assessment procedures were not discussed by these participants however on closer examination of the artistic theories underpinning their work, some formal assessment procedures were intuitively employed by the arts therapist (e.g. Laban Movement Analysis). DT participants widely integrated informal and formal assessment procedures into their practice. The formal procedures came from mainstream DT and OT practice. This study found that DTs were the most eclectic

of the arts therapists in terms of adopting and adapting procedures from their own other models of practice.

An integrative/eclectic theoretical approach underpinned the work of the arts therapists. This approach integrated psychotherapeutic, artistic and other discipline theories. An interesting finding in this study was that arts therapists influenced by psychodynamic theories, primarily the art therapists, tended to employ person-centred and artistic and other discipline theories in-session and psychodynamic theories outside the session in supervision (e.g. to explore the transference relationship) and in their session notes. The reason for this was because their clients were unable (due to the disease) to engage in a detailed exploration of the transference relationship during the session. This issue raised many questions for the arts therapists concerning how they defined their work. For example, was the work, particularly with clients in the later stages of dementia, more a therapeutic than an artistic intervention and if the former could this be considered arts therapy practice.

A further 'hot topic' for AT and MT was arts therapists integration of directive (pre-composed) and non-directive (improvised) elements within the session. Psychodynamically orientated arts therapists recognised that the client benefits from more direction in session as this reduces his/her feelings of confusion, however the arts therapists found it difficult to articulate the degree to which they were directive because this challenged the traditional non-directive (improvised) way in which they were trained. This uncertainty could be addressed by clarifying the level of psychodynamic psychotherapy that arts therapists work at with their dementia clients. For example, in the supportive therapy model the psychotherapist mediates between directive and non-directive approaches with the client in order to develop ego strengthening. Using the supportive therapy model as a foundation upon which arts therapists build a specific model of practice will help address this issue.

Statements of practice:

- *Arts therapists adopt and adapt mainstream arts therapies and non-arts therapies referral, assessment and evaluation procedures in order to meet specific needs of this client group. At present arts therapists undertake 'on the spot' referrals and use informal and some formal assessment and evaluation procedures. Arts therapists employ an integrative/eclectic theoretical approach drawing on psychotherapeutic, artistic and other discipline theories.*

- *The arts therapists have a preference for group and individual work with clients in the earlier to middle stages of dementia and one-to-one work with clients in the later stages of the disease. Due to economic factors group work predominates at present. Art therapists need to continue to press their employers for the inclusion of one-to-one work so that group work does not dominate the profession.*

- *Arts therapists use both directive and non-directive approaches in the arts therapy session. The degree to which psychodynamically orientated art therapists and music therapists employ these approaches is still under discussion. Clarifying the level of psychodynamic psychotherapy (e.g. supportive level) arts therapists work at with their clients will help to address this issue.*

Patterns of practice: emergent practice

The arts therapists and their clients work within a temporal session structure. The session structure can be considered temporal because clients are orientated at the beginning and end of the sessions. However, the therapeutic relationship (regular presence of the arts therapist and therapy space) and the art form (e.g. its symbolic and metaphorical quality) provide a constancy that transcends the temporality of the session structure. The findings suggest that in-session practice mediates continually between this temporal and constant dynamic.

There was some indication to suggest that the arts therapists were using multiple methods in their sessions. AT, DMT and DT participants were borrowing techniques from other art forms or other creative modalities in order to inform their own practice with this client group.

Statement of practice:

- *The arts therapists are engaged in emergent practice. They employ a specific temporal session structure that facilitates the orientation of their clients at the beginning and end of the session. The therapeutic relationship and art form provide constancy within this temporal context. AT, DMT and DT therapists may use multiple methods (techniques informed by other arts therapies/artistic traditions) during the session. Employing multiple methods provides the arts therapists with a wider repertoire of techniques with which to engage their clients.*

Patterns of Practice: life lessons

The work taught the arts therapists many life lessons. They learnt about the complexity of working with a person who has a progressive illness. *Staying with the not knowing* was one of the main challenges facing the arts therapists as he/she tried to work out what was going on in the session.

The arts therapists felt deeply moved by the work and by what they learnt from their clients. Through the work they confronted many assumptions and preconceived ideas they had about what it was to live with dementia. The arts therapists felt incredibly privileged to accompany the person during this period in his/her life.

Statement of practice:

- *Arts therapists believe that working with a person with dementia provides them with important learning opportunities, both professionally and personally. Through their work they learn to 'stay with the not knowing' and to accommodate the changing needs of their clients. In personal terms the work may evoke feelings about their own mortality and what it means to accompany their client on his/her final journey.*

Strengths and limitations of the study

Mapping the arts therapies and dementia field has been a considerable undertaking. Synthesising the working practice and related issues of four different arts therapies leaves the research potentially open to simplification. The rich and complex work of the arts therapists can be lost as the researcher strives to make sense of the whole field. The breadth of this study leaves it open to this criticism particularly in light of the fact that some areas of arts therapies and dementia practice could only be touched upon rather than given detailed consideration.

In terms of establishing trustworthiness in the study *credibility* was achieved by inviting participants to comment on their interview transcript, by undertaking participant observation in thirteen different care settings and by involving myself in the field via publications and conference presentations. I had one book chapter and one review published (Burns, 2006, Burns, 2007) I presented two poster presentations at national and international conferences; I did a conference presentation and a professional talk. All of these provided me with important feedback opportunities.

In this study every endeavour was taken to ground the study in the voice of the practitioners. However, there were constraints to c*redibility* primarily in the form of the multiple accounts of different practice that were offered by the arts therapists. Arts therapists are dynamic and creative people who are influenced by many different principles of theory and methods. Pulling all the elements of shared and

distinct practice together into a collection of practice statements has been challenging. The danger is that ideas and concepts underpinning individual arts therapies work are lumped together in order to present a complete picture of the field.

In terms of the *transferability* it could be argued that the study does represent the whole population of arts therapists working with people who have dementia. This is illustrated by the fact that thirteen arts therapists who were not currently working in the field decided to take part. This suggests that the motivation of arts therapists' to participate in the study, even when they had left the field, was high. Another reason for this claim is that the field is small and therefore more easily saturated. Constraints to transferability centre on the specialised nature of the study. The arts therapies and dementia field is small therefore transferability of the study to other research projects is a potential limitation.

In terms of *dependability* detailed consideration was given to the research methodology, procedures and methods during the course of the study. Every aspect of the study was discussed with the research team. Constraints to dependability centre on the flexibility of qualitative research. Many avenues are open for the researcher to explore during which copious amounts of research data may be collected. In this study over thirty sub templates were generated, all relating to different aspect of arts therapy and dementia practice. Synthesising such a large data set was challenging. Moreover, because of the volume of research findings generated from the arts therapists' interviews, limited consideration has been given to medical/care staff interviews.

In terms of *Confirmability* the subjective nature of qualitative research affords the researcher the opportunity to capture the nuances and subtleties of the phenomenon being studied. Constraints to credibility in this study centred on the assumptions that I brought to research having worked as an art therapist with older people who have dementia. Acknowledging my a priori knowledge of the AT field from the outset encouraged me to continually question the assumptions I was making about the work. Moreover, it led me to a body of nursing research literature that I would not previously have read because of my inaccurate assumption about the nature of research (quantitative) undertaken in this discipline. A strength of the

study has been employing a methodology from a field that is a construct of the biomedical model. It has made me think about the shades of grey that exist within the health professions. For example, the arts therapists dislike of biomedical labels but there are implications for practice of knowing about the disease and how to work with clients experiencing different stages of the disease. Constraints to confirmability centre on the fact no research methodology or set of procedures and methods can accommodate all the assumptions and biases that the researcher brings to the study.

Recommendations for clinical practice

Specialised training

The study has highlighted that arts therapists come to the field with little or no previous knowledge about working with this client group. This raises Issues about the generic training currently offered to postgraduate arts therapy students and the prioritising of certain client groups (e.g. children and adult mental health) over others (e.g. dementia). This study has highlighted that there is a need for specialised training in working with older people who have dementia. This is evidenced by the fact that the arts therapists in this study spent much of their time adopting and adapting mainstream practice. Offering a specific module on working with older people within the current generic training courses would begin the process of offering specialist training in the field. Perhaps if individual institutions do not have the resources to provide such a module this could be done on a national level (e.g. through their professional associations).

Securing employment

The arts therapists, in particular from AT, DMT and DT, and their professional associations need to target employers offering permanent contracts in order to create some job stability in the field. The days of arts therapists working as volunteers and sessional workers have gone. There is now an urgent need to pursue more fixed posts in order to consolidate existing practice knowledge and develop specialist expertise. This can be achieved by further research in the field which contributes to practice knowledge.

Clarifying the role of the arts therapist in the care setting

Arts therapy work with older people who have dementia has the potential for rapid expansion in the next few years as the world population ages. In order to aid this expansion there needs to be more clarification about the role of the arts therapist within the dementia care setting. In turn the arts therapists need to be more proactive about informing potential employers about their work. Consideration should be given to running a medical/care staff workshop before the arts therapists begins working with clients in the setting. This would mean that medical/care staff liasing with the arts therapists were fully aware how he/she works and vice versa the arts therapist would get to know the working practices of his/her colleagues. There are implications in terms of who funds the workshop (for sessional arts therapists this would be non-contact time with their clients) and how many medical/care staff can attend if they are shift workers. However, these obstacles can be overcome if running this type of workshop becomes standard practice.

In terms of clarifying the arts therapists' role in the setting, potential employers need to be more proactive in finding out about the arts therapy service that they are contracting into the setting. There is little point in employing arts therapists if what the employers want is an activity officer. Moreover, the idea that funding necessitates that much of the work is group work harks back to the tradition of the activity group. Arts therapists in this study have clearly stated that providing a mix of group and individual work is beneficial for the clients. Employers need to consider this point and not assume that group work is always best for the client.

Developing practice knowledge specific to clients with dementia

This study has illustrated that the arts therapists are engaged in emergent practice. In order to work with their clients who have dementia arts therapists have had to adopt and adapt mainstream procedures and develop their own session structure and in-session methods. Developing practice knowledge specific to this client group needs to continue. Each aspect of the arts therapy intervention requires revisited and further refined in order to generate a comprehensive working model.

Recommendations for future research

Discipline specific research

The aim of this study was to map the arts therapies and dementia field and to offer some interpretation on the map. Mapping enables the roads and geographical features of the landscape to be outlined. The aim for future research is to undertake a more detailed study of each section of the map. This means that arts therapists from the four disciplines need to conduct further in-depth research that looks at specific areas of practice. This study has highlighted that a different type of session structure operates when arts therapists work with clients who have dementia. It would be useful to see how this structure changes as the person moves through the disease. This would, perhaps, involve a longitudinal study undertaken over several years. Each aspect of therapy work could be revisited and explored in more depth.

Developing practice statements and guidelines

One aim of this study was to generate a set of practice statements would be of value to practising arts therapists. The development of practice statements is something that future researchers could begin with but take further. There is need to build on the momentum of this study and return to each area of the descriptive map and undertake an in-depth investigation into that area. For example, there is an urgent need to develop comprehensive referral and assessment procedures so that practitioners working in voluntary and private care settings have some criteria for referring and assessing their clients. Arts therapists in these settings are totally reliant on care staff to refer clients to them and this causes initial problems because they have little say in group size, compatibility and whether or not individual therapy is an option. Developing practice statements from research studies undertaken in the field and taking these back to practitioners for further refinement will help address gaps that exist within our understanding of arts therapy and dementia practice. Moreover, the seed that begins life as a practice statement has the potential to germinate into a practice guideline following systematic review or in the case of Sheppard and Waller (2006) a longitudinal control study.

In terms of who should conduct the research study it would be valuable for someone who has knowledge of the arts therapies field, not necessarily the specific discipline. Waller and Sheppard's (2006) study was multi-disciplinary; Waller is an art therapist and Sheppard a psychologist. Undertaking research with colleagues from outside the profession is one way for arts therapist to develop their knowledge of the research process and to provide evidence of the effectiveness of the arts therapies with this client group. Arts therapists are traditionally qualitative researchers. Odell Miller's (1995) abandonment of her quasi control trial in favour of case study descriptions illustrates this point. However, in order to develop practice guidelines arts therapists perhaps need to engage with both qualitative and quantitative research traditions. Interventions looking at the effectiveness of each aspect of arts therapy practice outlined in this study will aid future development of the field.

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Appendix A - Models of Personhood and Positive Person Work

Kitwood's (1997) concept of Personhood recognised the person's five basic psychological needs. The first was the person's need for a*ttachment* that the person has access to an attachment figure in his/her life. The person needs *love and comfort* from the people around him/her. *Inclusion* the person needs to be accepted by other people and feel part of the group. *Occupation* signifies the person's need to be engaged in a purposeful activity. *Identity* means that the person should be able to maintain a sense of self, that his/her life story is told and valued. In this way there is a continuation of the person's personal narrative.

Kitwood (1997) introduced a twelve-step *positive person work* model for care staff to use when working with the person. Amongst the twelve steps are *Recognition*, the person is accepted as a person; *Negotiation*, the person is able to make choices about what he/she wants; *Collaboration*, the person collaborates with others and shares his/her abilities and skills; *Play* the person is free to engage spontaneously in an activity, to express him/herself and to have fun; *Timulation*, the person's sensory/stimulatory world is maintained through engaging in tactile activities such as art making or massage. *Celebration*, the person celebrates important occasions. *Relaxation*; the person has time to unwind and relax; *Validation,* the person's experiences are valued and acknowledged*, Holding,* creating a place of safety where the person can feel safe to share his/her feelings. *Facilitation* the person is helped to do what s/he wants to do. *Creation,* the person participates in the group by offering something that she/he can do. *Giving* the person is able to express how she is feeling (Kitwood, 1997, Kasayka, 2001)

Appendix B - Development of the Interview and Analysis Template

4 stage development – from interview schedule to guide template			
2004 - Interview schedule	**2005 - Interview schedule** Ongoing analysis	**2006 - Analysis guide (1)**	**2006 – Analysis guide (2)**
1) Involvement in the field • Current involvement in the field • Reasons for interest in the field	1) Background • Prior career/training • Reasons for interest in dementia field • Current work	1) Background *Entering the field* • Prior career/training • Where trained • When trained Reasons for choosing dementia field *Current Work* • Dementia work • Diversified work	1) Professional Background • Prior career/training • Where trained • When trained • Reasons for choosing dementia field
2) Theoretical orientation • Arts theory • Dementia • Psychotherapy • Other	2) Setting • Type of setting • Therapy space • Resource provision	2) Older Person *Biomedical* • Stages of dementia experienced by older person *Psychological and emotional* • Psychological and emotional issues experienced by the older person with dementia	2) Current Dementia Work of Arts Therapists • Current dementia work • Current other work
3) Theory – Practice Link • Setting • Older person • Session organisation • Therapeutic intervention • Practicalities of practice •	3) Older Person • Types/stages of dementia • Psychological needs • Response to therapy • Significance of therapy	3) Setting • Type of setting • Type of therapy space • Resource type and provision	3) Older Person *Biomedical* • Stages of dementia experienced by older person *Psychological and emotional* • Perceived psychological and emotional issues experienced by the older person with dementia 4) Setting • Type of setting • Type of therapy space • confidentiality/ boundaries

4) Knowledge of other practising therapists • Advisers knowledge, in general terms, of how other therapists are working in practice. • Adviser's knowledge of the name(s) and location(s) (if happy to give this information of other practicing therapists.	4) Practice • Sessions construct • Therapy process • Assessment/Evaluation • Other practicalities 5) Theory • Arts theory • Dementia • Psychotherapy • Other	4) Therapy work *External structure* • Assessment and evaluation procedures • Confidentiality/boundaries • Duration of sessions • Duration of therapy • Group/individual • Group numbers *Internal structure* • What happens in a session? *Theory* • Psychotherapy • Arts theory • Other • Theoreticians 5) Therapist • Perceptions of role and identity • Challenges of job • Rewards of job • Other work comparison 6) Interdisciplinary work • Collaboration	5) Therapy work *Referral and Assessment* • Referral Group/individual/ Group numbers Staff help • • assessment • Evaluation 1. Duration (sessions/ therapy) 2. Supervision *In session* • Theory 1. theoreticians • Methodology • Method 1. Props and materials 6) Therapists Reflections *Relating to older person* • Therapists' perception of the significance of therapy work for the older person *Relating to therapist - staff* • Interdisciplinary dynamic *Relating to therapists role* • Rewards of work • Challenges of work (relating to older person) • Challenges of work (external) • Other work comparison

Appendix C - Example of Participant Observation Prompt Sheet

Setting code:
Therapist code:
Date

1. Characteristics of participants

Gender:
Age:
How long in the profession:
Any other information:

2. Clients

Number of clients in the setting:
Dementia specific unit or mixed client group:
Any other information:

3. Setting:

Location
Physical surroundings (inside/outside)
Overall impressions of the setting

3. Interactions (verbal and non-verbal)

Between staff and clients
Between staff and staff

5. Activities taking place in setting

Type of activities:
How often:
Group or individual:
Any other information:

6. Therapy space

Shared/dedicated space:
Size:
Location within the setting:
Suitable/issues for therapist in term of space:
Any other information:

7. Informal comments from staff about the arts therapy service

9. What were the main issues that struck me about the setting/therapy service

10. What information did I fail to get?

Appendix D - Example of Sub-Template Relating to Theory

Therapy Work (Theory) (**blue** = lower order (from guide), title category, **yellow** = middle order title category, yellow = middle order general category and (yellow) = middle order sub-category			
AT	MT	DT	DMT
Person –centred The relationship Person-centred is about the way you are with the client, so engaging in the core conditions. (2AT9) I think the person-centred approach is really good for this client group especially with people in late dementia. All you can give them I think is just being there with them. Many have lost their ability to coordinate, to pick up a pencil …. (2AT3) I actually went towards the person-centred approach so that is how I work (2AT3) The 'here and now' I think when you come to work with this client group and you find yourself working in the 'here and now' you come to realise that a lot of this work does not match traditional training (2AT5) Contra- statement The person-centred approach is too easy an approach to use. It is just taking what you see and dealing with what you see but you need to have a theoretical background in order to understand what emerges from therapy. (1AT13)	**Person –centred** The relationship One of my influences is Kitwood, and his idea of the psychological needs of people, comfort, attachment, inclusion occupation, identity and that kind of thing. He formulates a list of positive interactions between carers and dementia sufferers. Amongst these are recognition, negotiation, collaboration, play, etc. (1MT7) The 'here and now' I think it is just going with what works in the moment (2MT14) What interested me was Kitwood's work from the tradition of humanistic psychology, and humanistic psychology was one of the main influences on Paul Nordoff and Clive Robbins (1MT7) The work is client centred I developed a sense of the importance of the 'here and now' rather than specifically working for change and growth. Tom Kitwood's theory of Personhood enabled me to contextualise my approach within a broader theoretical framework. (1MT10) Well the main people that we keep talking about are Rogers and the client–centred approach	**Person –centred** The relationship The focus of these sessions is nurturing the self and others. (1D1) To an extent all of my work is developed around the needs of the individual client group I worked with. (1D12) (valuing) I think that the person-centred approach is about really valuing that person obviously and kind of realising that they need help to access things and to remain their own person, a unique individual. (2D2)	**Person –centred** Expression I think in terms of approach it is about recognising that through the movement you tap into a person's whole being and allowing that to express itself. I was influenced by Kitwood (1DMT5). (connection) My role is helping my clients to hold on to the 'well' part of them. Certainly in the ward because everything around them is so crazy so 'touching the wellness' I feel that is my role in that setting. (2DMT19) 'here and now' The process is being in the 'here and now' and actually finding a way of communicating which is something that my clients have struggled with for a long time. (2DMT1) The relationship I really appreciate Kitwood's 'I' ,'thou' position. Meeting the person where he/she is at. (1DMT15) Our model here is

	(2MT16)		very much humanistic, very person centred, very Rogerian (1DMT3) The main thing is that I am person-centred so the relationship is important to me. (2DMT17) My role is trying to encourage people into being what they can be (1DMT8) (choice) I gave my clients choices as in 'what do you want to do?' and also the choice not to join in (1DMT8)

Appendix E - Example of Sub-Template Relating to Methods

Therapy Work (Methods/beginning of session) (**blue** = lower order (from guide) title category, **yellow** = middle order title category, yellow = middle order general category, (yellow) = middle order sub category.			
AT Beginning (orientating/structuring I would make suggestions to get clients started - especially clients who were in the early stages (2AT11) I would lay the materials out in a similar way each week. (2AT17) I draw with clients, to help to orientate them (1AT6) I have found with some patients that the squiggle drawing is really helpful to get them started (2AT5) I give my clients some simple exercises to get them out of that idea that they needed to do something that was aesthetically pleasing (2AT1) It is quite a gradual process because to bring out drawing materials straight away to a new group or a new resident is quite threatening for them unless maybe they have drawn before. We usually start with collage work. (2AT4) In the first session I explained to the clients that the art therapy was for them to do what they wanted. Maybe they were unsure how to squeeze the paint	MT Beginning (orientating/structuring) I might suggest that we do some drumming something very basic and part of that is that it is the kind of rhythmic aspect that helps people to feel connected because it can be difficult to make connections. (2MT7) Generally, the structure is arrive, introduction and welcome and then we might start with a song or just wait to see what happens. Someone might pick up an instrument (2MT14) Someone might be wandering so often it can be very split, disconnected and it is about musically trying to find my connector. I think that is the thing. I have seen, recently I brought my violin and it was quite interesting because it was the three women who are now in the group and each one responded quite significantly to the sound of the violin, it was quite something. (2MT14) I always start with a song and see how they are and then often they will say or do something that then sets us off (2MT16) Sometimes we just get the clients together for some singing and then work with individuals. (1MT2)	DT Beginning (orientating/structuring) It was really important to do a sort of name game, because clients would forget their names, you know, from one session to another (1D9) One session began with a drawing of a tree, the following session you have to start again you know with something new and so each session is kind of very self-contained (1D9) I played the guitar and we would sing a song to start the session off (1D9) I have a kind of opening ritual which I have just developed over the years. I have a mascot figure which will be a soft toy figure or whatever it becomes, a friend to the group and the group will give this figure a name (2D6) We begin with the soft toy and go round the room with it. I sometimes also use another continuing ritual I have a plastic cart, a big thing they hold on to and we do around of that and then I have got a big brass car hooter and it makes a lovely raspberry sound and we will do a round of what I call 'naff' things anything that has been a bit of a drag (2D6) We talked about creating a threshold so I got a cymbal and smashed the cymbal before the drama would start and a cymbal to end it	DMT Beginning (orientating/structuring) We would start with some music (1DMT8) I usually introduce a ball. It is good for introducing 'I' and 'how', for coordination skills. As soon as you introduce the ball you introduce direct contact so it is a focus that people follow and it is so clear, it is an object, a visual image and also there is the motion of throwing and catching sometimes you are so surprised to see how easy people manage. I would perhaps have some music on to start off but I would always have a welcoming introduction going round if possible welcoming each person and maybe getting people to say how they feel if they can and then often throwing a ball to begin that interaction with people. (2DMT19) I've always got a few ideas in the back of my head to pull out if they get into a really stuck place but often it just develops (1DMT3) I would ask the group what they want to do (1DMT3) It seemed to me here that the music was important, playing the

bottle so then I would ask them what colours they wanted but otherwise I left them to decide what to do. (2AT17) (sorting objects) When they are in the later stages of dementia it is not so much about making images it is more about sorting objects or ripping paper, using textured material (2AT5) (word game) Well I have one exercise that I find particularly helpful it is not based on any theory it is just something that I discovered around giving people a word or actually asking them to pick a word of their choice and then I would ask them three questions 'what shape does it have', 'what colour does it have' and 'how does it feel' and based on that we would link that to the materials the person chose, the colour of the material and the first paint went on the paper. (2AT11) (sensory) I would put a range of sensory materials on the table and so people would pull them and have things in front of them and treat them in a way as a sculpture (2AT8) (hats) I collected hats a dramatherapist gave me the idea. They would put on hats I would never put a hat	We usually have sessions where we choose an instrument and I am usually at the piano and we play together (2MT2) In the group I would do a 'hello' song and because at this stage of the group the members seem to be quite isolated from each other and not acknowledging each other I usually pass round an instrument that is quite a task at the moment in getting someone to pass it to another person and actually play it because some clients don't now what it is. You know even if it is a relatively familiar instrument the stage of their dementia may mean that they don't recognise it so it may be a slow kind of passing round of the instrument. (2MT2) I would probably show them the instruments explain and maybe demonstrate how you play them what you do (2MT2)	(1D9) I encourage clients to move around and touch and feel objects in their environment if they are able or to extend the movement that they already make sounding out rhythms, encouraging eye contact and repetition of speech patterns. (1D1)	same piece of music for the warm up. (2DMT17)

on somebody often carers would come in and plonk a hat on the person. (2AT8)			